VAN NATTA'S
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This volume is a compilation of Orders of the Oregon Workers' Compensation Board and decisions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law.

Owing to space considerations, this volume omits Orders issued by the Workers' Compensation Board that are judged to be of no precedental value.

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CITE AS

46 Van Natta ___ (1994)

In the Matter of the Compensation of
JENNIFER BORDERS, Claimant
WCB Case No. 93-04440
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Black's order which set aside its denial of claimant's current low back condition. On review, the issue is compensability.

We adopt and affirm the Referee's order, with the following supplementation.

Subsequent to the Referee's order, the court held in Beck v. James River Corp., 134 Or App 484 (1993), that medical treatment for a compensable condition under ORS 656.245(1) is compensable if the treatment bears a material relationship to the compensable injury. The court distinguished a claim for continued treatment for a compensable condition from a claim for a new or different condition, explaining that ORS 656.005(7)(a) applies only to initial compensability determinations; i.e., "to claims for new injuries or conditions different from an already accepted claim." 124 Or App at 488.

Here, claimant seeks continued treatment for her chronic low back condition, originally caused by work injuries in 1970. She is not seeking compensation for a new or different condition, nor does the medical evidence establish the existence of a new or different condition requiring medical treatment. Accordingly, we find that the Referee correctly applied the material contributing cause standard under ORS 656.245(1). After our review of the record, we agree with the Referee's determination that claimant has proven that her current need for medical treatment is materially related to her compensable 1970 back injury.

The insurer urges us to uphold its denial on the basis of our previous decisions in Estevan Lara, 44 Van Natta 2503 (1992); Marie M. Sax, 44 Van Natta 2152 (1992); and Ronald J. Lucier, 44 Van Natta 1268 (1992). We find these cases distinguishable, because all three involved aggravation claims for conditions different from the accepted injury.

In all three cases, the claimants first had to prove that the later condition was compensable under ORS 656.007(a)(A), because the "current" condition was not directly caused by the industrial accident. In the above-cited cases, the claimants had to prove both causation under ORS 656.005(7)(a)(A) and a worsening under ORS 656.273. See Gray v. SAIF, 121 Or App 217 (1993), aff'g Bertha M. Gray, 44 Van Natta 810 (1992); Thomas L. Fitzpatrick, 44 Van Natta 877 (1992), aff'd by evenly divided court Fitzpatrick v. Beaverton Welding, 127 Or App 560 (1994).

Here, however, claimant sought only continued medical treatment for the same compensable condition. Our decisions in cases involving aggravation claims for different conditions are not applicable to the present case.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 10, 1993 is affirmed. Claimant's attorney is awarded $900 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
LARRY BECKEMEYER, Claimant
WCB Case Nos. 92-16096 & 92-12234
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roderick D. Peters (Saif), Defense Attorney
Crispin & Associates, Defense Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Crumme's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral hand condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant worked as a bartender from July 1991 through November 1991. Prior to that date, claimant worked as a car salesman and radio announcer.

In September 1991, the bathroom in claimant's house was remodeled. Although the work primarily was performed by claimant's wife, she was assisted at times by claimant and a friend.

In February 1992, claimant sought treatment for right hand and arm pain from his family physician, Dr. Guappone. (Ex. A-1). In April 1992, upon Dr. Guappone's referral, claimant was evaluated by Dr. Rosenbaum, neurologist, who diagnosed bilateral carpal tunnel syndrome. (Ex. 3). That same month, claimant underwent surgery for the right hand. (Ex. 5). In October 1992, surgery for the left hand was performed. (Ex. 18A).

In May 1992, claimant filed a claim for his bilateral hand condition, alleging that it was caused by repetitive activities performed while working as a bartender. (Ex. 6).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to prove that the major contributing cause of his bilateral carpal tunnel syndrome was work activities as a bartender. See ORS 656.802(2). Claimant challenges this conclusion, asserting that he proved compensability of his condition.

When claimant first sought treatment from Dr. Guappone on February 4, 1992, he reported that he had awoken approximately one month before "with an uncomfortable, tingly arm pain down his arm." (Ex. A-1). Dr. Guappone subsequently concurred with a report drafted by claimant's attorney stating that claimant's work was the major contributing cause of his carpal tunnel syndrome, adding that the nature of the work, timing of symptoms, and absence of any other precipitating cause supported his opinion. (Ex. 25).

Claimant provided a similar history to Dr. Rosenbaum on April 2, 1992, reporting that he awoke on December 31, 1991 with right hand and arm numbness that gradually worsened. (Ex. 3-1). Based on this history, Dr. Rosenbaum reported that claimant's condition was idiopathic and not related to work activities. (Ex. 24).

In November 1992, claimant reported to the panel of Dr. Stanford, orthopedic surgeon, and Dr. Peterson, neurologist, who examined claimant at SAIF's request, that the onset of numbness and tingling in his hands was during the first or second week in October 1991. (Ex. 20-1). Based on the absence in claimant's history of "exposures that typically cause carpal tunnel" as well as physical conditions such as diabetes and thyroid disease, the panel found that claimant's work was the major contributing cause of his bilateral carpal tunnel syndrome. (Id. at 3). Dr. Button, hand surgeon, who examined claimant in January 1993 at SAIF's request, provided a similar opinion. (Ex. 22A-3).

Dr. Button subsequently reviewed the medical reports showing that claimant informed Dr. Guappone and Dr. Rosenbaum that his onset of symptoms was in December 1991, after he stopped working. Based on this information, Dr. Button found that his work was not the major contributing cause of his hand condition because "there was no reported carpal tunnel symptomatology during his period of employment." (Ex. 23). Dr. Stanford concurred. (Ex. 26).

Claimant testified at hearing that he first noticed symptoms in late September or early October 1991. (Tr. 42-43). When based on this history, the medical evidence supports compensability. We are unable to conclude, however, that such a history is accurate. Claimant's reporting of his history was inconsistent in that he initially dated the onset of symptoms in December 1991 and then related that they began while he was working as a bartender in October 1991. Claimant's only explanation for such inconsistency was his testimony that he told Dr. Rosenbaum that his symptoms significantly worsened, rather than began, in December 1991. During a deposition, Dr. Rosenbaum explained that, because sudden onset of carpal tunnel symptoms is unusual, he closely questioned claimant regarding the history of his symptoms. (Ex. 27-9). In light of this evidence, we find it unlikely that Dr. Rosenbaum misunderstood claimant's reporting of his history.

Furthermore, even assuming that claimant proved that the onset of his symptoms was in October 1991, we would continue to find that the medical evidence supporting causation was not persuasive. First, Dr. Rosenbaum explained that, although some bartending activities could cause carpal tunnel syndrome, they would have to be repetitively performed many times. (Ex. 27-8). Therefore, according to Dr. Rosenbaum, it would be necessary to know the volume of business in order to render an opinion; although serving ten customers an hour would not be sufficiently repetitive, Dr. Rosenbaum stated that serving 50 customers an hour would likely cause claimant's condition. (Id.)

According to the employer, the bar's capacity was 42 or 48 people. (Tr. 62). Claimant's wife, who frequented the bar weekly while claimant was working, testified that usually about ten customers were present. (Id. at 36). Claimant estimated that, on average, he served about 200 drinks during a seven hour shift. (Id. at 13). Based on such evidence, we find that the record does not show that the volume of business rose to the level described by Dr. Rosenbaum as necessary to cause carpal tunnel syndrome.

Furthermore, claimant testified that he experienced symptoms while performing bathroom remodeling work. (Tr. 67, 70). In view of Dr. Rosenbaum's testimony that repetitive activities such as hammering, painting and sanding could contribute to the development of carpal tunnel syndrome, (Ex. 27-14), we find that the absence of such a history in the medical opinions finding a causal relationship between bartending activities and claimant's condition further undermines their reliability.

In conclusion, in assessing the medical evidence supporting causation, we are unable to conclude that they are based on an accurate history with regard to the onset of symptoms and they are not based on a complete history in that they do not consider claimant's remodeling activities. Consequently, we find them unreliable. See Somers v. SAIF, 77 Or App 259 (1986). Thus, having failed to show that his work activities were the major contributing cause of his bilateral hand condition, compensability was not proved. See ORS 656.802(2).

ORDER

The Referee's order dated June 16, 1993 is affirmed.

In the Matter of the Compensation of
PATRICIA D. CARTY, Claimant
WCB Case No. 92-13320
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Tenenbaum's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a psychological disorder. In addition, claimant moves the Board for an order remanding the case to the Referee for the admission of additional evidence. On review, the issues are remand and compensability. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant contends that the Referee erred in refusing to admit the whole of Exhibit 8 into evidence at hearing. Claimant initially offered Exhibit 8, the SAIF Corporation's investigative report of claimant's claim, into the record. SAIF objected on the basis of hearsay. (Tr. 2). The Referee declined to admit it "as a substantive matter." (Tr. 4).

Later, after Ronald Nelson, the employer's witness, testified, claimant offered pages 2 through 7 of Exhibit 8 for purposes of impeachment. The Referee admitted that portion of Exhibit 8 for impeachment. (Tr. 106-107). The Referee also admitted the same portion as substantive evidence in lieu of Nelson's testimony. (Tr. 108). Claimant further offered, and the Referee admitted, pages 7 and 8 of Exhibit 8 to impeach Alice Dudley, another of the employer's witnesses. (Tr. 126).

During cross-examination of SAIF's expert, Dr. Glass, claimant inquired whether the expert had reviewed Exhibit 8 before the hearing. The expert responded that he had read the report which had not changed his opinion, but had reinforced it. He also indicated that the admitted portions of the report were "on the top of his head" and that the remainder of the report was not significant to his psychiatric diagnosis. (Tr. 143-146, 148). Claimant again offered the report into the record and SAIF objected. (Tr. 145-146).

On May 24, 1993, after the hearing record had closed, claimant made an offer of proof. The Referee rejected the offer of proof as untimely. (Opinion and Order at 1).

Claimant argues that the Referee failed to state the reason for excluding the proffered evidence and contends that the evidence was admissible under three exceptions to the hearsay rule, as well as the Board's policy to promote the "full and complete disclosure of all facts and opinions pertaining to the claim being litigated," pursuant to OAR 438-07-015(5). (Appellant's Brief at 4-5). Claimant contends that, because of the Referee's error, the record was not fully developed.

We may remand a case to the Referee for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the referee. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988). However, before we address claimant's remand motion, we first respond to claimant's contention that the Referee erred in declining to admit the whole of SAIF's investigative report.

ORS 656.283(7) sets the standards by which evidence is admitted in workers' compensation hearings. The statute specifies that the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7). Referees have broad discretion when rendering procedural and evidentiary rulings. Lyle A. McManus, 43 Van Natta 863 (1991).

The Referee originally excluded the entire investigative report as substantive evidence, but later admitted pages 2 through 6 as both substantive evidence and for purposes of impeachment, and pages 7 and 8 solely for purposes of impeachment. Claimant then sought the admission of the remaining part of the investigative report, because it was a basis for SAIF's expert's opinion. Claimant did not establish any other ground for admitting the remainder of Exhibit 8.[1] We recognize that the report could have come in on the basis urged by claimant, but it was not an abuse of discretion for the Referee to exclude it since, according to the expert, the report had only reinforced his opinion and was not a significant factor in forming his opinion. Furthermore, claimant, who had sought the admission of the entire exhibit since the beginning of the hearing, had ample opportunity to make an offer of proof prior to closure of the record. Consequently, we find that the Referee did not abuse her discretion either by excluding the evidence or by disallowing claimant's untimely offer of proof.

Moreover, in light of the failure of claimant's doctors to establish that she had a mental or emotional disorder caused by work, we are not convinced that admission of the remainder of Exhibit 8 would reasonably affect the outcome of the case. See Compton v. Weyerhaeuser Co., supra. Therefore we find no reason to remand.

Compensability

We adopt and affirm the Referee's opinion on this issue.

ORDER

The Referee's order dated June 15, 1993 is affirmed.

[1] Claimant's citation to OAR 438-07-015(5) is inapposite, as that rule governs the provision of discovery, not the admission of evidence at hearing.

In the Matter of the Compensation of
RICKY S. CRITTENDEN, Claimant
WCB Case No. 93-09104
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Bethlahmy's order that set aside its denial of claimant's occupational disease claim for an ulcer/lesion on claimant's right leg stump. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following comment.

The Referee concluded that the ulcer/lesion on claimant's right leg stump was caused in major part by his walking and standing at work while wearing a right leg prosthesis. On review, SAIF correctly notes that the Referee does not discuss the medical basis for her opinion.

Given the Referee's ultimate compensability ruling, we conclude that she relied on the opinions of the treating physicians. Dr. Canepa, claimant's treating orthopedic surgeon, opined that claimant's use of his prosthesis at work was "the primary contributing cause to his cutaneous breakdown on the leg." (Ex. 14). Dr. Wade, claimant's long-time treating orthopedist, opined that claimant's job activities significantly affected, in a major way, the breakdown in his stump. (Ex. 10 and 13).

Drs. Canepa and Wade both explained that claimant's history of stump breakdowns had taught him to limit his off-work prosthetic use and weight-bearing activity. Both doctors noted that claimant used his prosthesis primarily at work, where he spent a significant amount of time walking and standing. Accordingly, Drs. Canepa and Wade reasoned that claimant's work was the major cause of his current stump breakdown.

We generally defer to the treating physician's opinion absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to defer to the reports of Drs. Canepa and Wade. Both opinions are well-reasoned and based on a thorough understanding of claimant's work activities. Moreover, we are not persuaded by the contrary opinion of Dr. McKillop, who examined claimant on behalf of the insurer. (Ex. 12).

Dr. McKillop opined that the major cause of claimant's stump breakdown was his prominent bony patella and the delicate scar tissue at the knee. Elsewhere in his opinion, however, Dr. McKillop opined that the wearing of the prosthesis at work "caused the breakdown." Moreover, his opinion as a whole indicates that the scar tissue and prominent patella were predispositions rather than actual causes for claimant's breakdown. See Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991) (susceptibility/predisposition to a disease not considered in major contributing cause analysis).

We, therefore, defer to the opinions of Drs. Wade and Canepa and conclude that claimant has established a compensable occupational disease claim. Accordingly, we affirm the Referee's order with the supplemental medical analysis set forth above.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 1, 1993 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
RAPHAEL IBARRA, Claimant
WCB Case No. 92-11216
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys

Claimant requests reconsideration of our June 2, 1994 Order on Review, which awarded him 13 percent unscheduled permanent disability. Claimant asserts that we miscalculated his adaptability factor in light of England v. Thunderbird, 315 Or 633 (1993).

In order to further consider claimant's contentions, we withdraw our June 2, 1994 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, the Board shall proceed with its reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID A. McINTYRE, Claimant
WCB Case No. 93-10350
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Garaventa's order that upheld the SAIF Corporation's denial of his injury claim for a cervico-dorsal strain. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation.

The Referee found that claimant had not established compensability of his cervico-dorsal strain. We agree.

The sole medical opinion relating the strain causally to the compensable electrical shock injury came from Dr. McGill, D.C. who stated:

> "Since [claimant] can relate no other incidents, etc., that would account for his current symptoms, I must assume that his current condition is the result of the most traumatic event that has happened to him thus far: the electrocution on 6-24-94."

Citing ORS 656.266, the Referee found this opinion insufficient to establish causation. ORS 656.266 provides that the worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred. In addition to the Referee's reasoning, we are not persuaded that Dr. McGill's assumption of a causal relationship is sufficient to establish that it is medically probable that the electrical shock caused the strain.

On Board review, claimant argues that this is an uncomplicated situation where medical evidence is not necessary to establish causation. We disagree.

In Barnett v. SAIF, 122 Or App 279 (1993), the court reversed a Board order that upheld a back injury denial because no physician had offered a medical opinion relating the claimant's back condition to her work activities. Citing Uris v. Compensation Dept., 247 Or 420 (1967), the court listed five relevant factors for determining whether expert evidence of causation is required: (1) whether the situation is complicated; (2) whether the symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a supervisor; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any contrary expert evidence. In Barnett, the claimant had never experienced low back pain previously, had suffered immediate low back pain after the injury, had reported the incident to her employer the next day and had sought medical treatment within 24 hours. In addition, there was no medical evidence which indicated that the injury did not cause the back condition. Under those circumstances, the court held that the claimant was not required to introduce expert medical testimony to prove causation.

Here, we conclude that the situation is complicated since claimant alleges that his electrical shock caused a muscle spasm which in turn caused a cervical strain. Although claimant's electrical shock was witnessed and claimant sought medical treatment for it immediately, his neck symptoms did not begin until the day after the injury and were not promptly reported to the employer. In addition, claimant did not seek medical treatment for the neck condition until two months after the electrical shock.

Under these circumstances, we conclude that whether claimant's cervico-dorsal strain is compensably related to the electric shock injury is a complex medical question. Thus, expert medical evidence is required in order to establish compensability of the cervical condition. Since the only medical opinion concerning the causation of claimant's cervical condition is insufficient to relate the neck condition to the shock injury, we agree with the Referee that claimant has not established compensability of his cervico-dorsal strain.

ORDER

The Referee's order dated November 29, 1993 is affirmed.

In the Matter of the Compensation of
BARBARA SIMMONS, Claimant
WCB Case No. 92-14607
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Mongrain's order that set aside its denial of claimant's current low back condition at L2-3. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, we do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, in accepting claimant's low back injury, the insurer had accepted claimant's preexisting degenerative disc disease at L2-3. Based on this reasoning, the Referee concluded that the insurer was barred from denying the previously accepted degenerative disc disease. See Bauman v. SAIF, 295 Or 788 (1983). On review, the insurer contends that it accepted only a lumbar strain incurred on January 11, 1987. We agree.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9). However, where an insurer accepts a symptom of a disease, it also accepts the disease causing that symptom. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988).

Here, the claim was accepted on January 27, 1987 on the 801 claim form. (Ex. 1). The claim form describes an injury to the back. Box 46 of the form, which asks for a full description of the accident, states: "Moved bed and pull [sic] back muscles or hurt back." Id. In a January 14, 1987 chart note, Dr. Gilsdorf gives his impression of claimant's condition as: "acute lumbar strain syndrome, with aggravation of chronic mechanical lumbar instability." The chart note also indicated that x-rays showed "retro displacement of L2 on 3 of approximately 50% narrowing of L2-3 disc space with marginal osteophytes, and slight narrowing of L5-S1, but no change in alignment." (Ex. 2). The first medical report filled out by Dr. Gilsdorf on January 23, 1987, gives claimant's diagnosis as "acute lumbar strain syndrome." (Ex. 3).

Claimant contends that Georgia Pacific v. Piwowar, supra, governs the present case. Specifically, claimant points to the language describing claimant's injury in box 46 of the 801 claim form and argues that the insurer accepted a "hurt back" which claimant argues is a symptom of the degenerative condition. We disagree.

Box 46 of the 801 is a description of how the injury occurred. It explains that, while moving a bed at work, claimant pulled muscles or hurt her back. Although the claim form does not describe the nature of claimant's injury, the medical evidence available to the insurer at the time of claim acceptance indicates that claimant's injury was diagnosed as "acute lumbar strain syndrome with aggravation of chronic mechanical lumbar instability." (Exs. 2; 3). We note that Dr. Gilsdorf's January 14, 1987 chart

note contains some findings relating to the degenerative condition. However, Dr. Gilsdorf's official diagnosis of claimant's condition was of "acute lumbar strain syndrome." (Ex. 3). Accordingly, based on the evidence in the record, we conclude that the scope of the insurer's acceptance was limited to the condition diagnosed by Dr. Gilsdorf. See SAIF v. Tull, supra.

Having concluded that the scope of the insurer's acceptance did not include the degenerative condition at L2-3, we turn to the merits of the insurer's denial of claimant's current low back condition at the L2-3 level. Because the medical evidence indicates that claimant's compensable injury combined with her preexisting condition to cause or prolong disability or a need for treatment, claimant must establish that the compensable injury is the major contributing cause of her resultant disability or need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409, on recon 120 Or App 590 (1993). Several physicians address the causation of claimant's current low back condition. Dr. Kirkpatrick, neurologist, saw claimant for a second opinion regarding low back surgery proposed by Dr. Dunn. Dr. Kirkpatrick opined that the major contributing cause of claimant's current disability and need for treatment is her preexisting degenerative condition and not the January 11, 1987 injury.

Dr. Englander examined claimant for the insurer. Dr. Englander opined that the degenerative disc change at L2-3 with retrolisthesis of L2 on L3 and large left-sided spur all preexisted claimant's January 11, 1987 injury since they were clearly present on the initial x-rays. Dr. Englander further noted that an MRI scan done four years after the injury did not show significant progression of that pathology. Dr. Englander opined that the underlying degenerative disc disease, rather than the January 11, 1987 injury, is the major cause of claimant's L2-3 condition.

Dr. Dunn is claimant's treating doctor. He believed that claimant had a preexisting narrow intervertebral foramen which predisposed claimant to nerve root irritation in the area of the narrowing at L2-3. Dr. Dunn explained that the January 1987 injury caused the nerve at L2-3 to be injured and caused it to become enlarged in the narrowed foramen causing further irritation of the nerve. Because of continuing irritation, the nerve did not heal normally and there were pathological changes in the L2-3 nerve. Based on this reasoning, Dr. Dunn opined that claimant's current disability and need for treatment is caused in major part by the January 11, 1987 injury.

Drs. Dinneen and Snodgrass examined claimant for the insurer. They opined that the January 11, 1987 injury was the major contributing cause of claimant's current condition.

We generally give greater weight to the opinion of claimant's treating doctor unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to defer to Dr. Dunn's opinion. In addition, we find Dr. Dunn's opinion to be both well reasoned and based on complete information. Accordingly, we find his opinion persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986). Based on this record, we conclude that claimant has established the compensability of her current low back condition at L2-3.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 14, 1993 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
KELLY J. HOBENSACK, Claimant
WCB Case No. 91-14648
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that portion of Referee McWilliams' order that upheld the insurer's denial of claimant's claim for his left arm injury. In its brief, the insurer disagrees with that portion of the Referee's order which found that claimant established good cause for his untimely hearing request. On review, the issues are timeliness of claimant's hearing request and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness/hearing request

We adopt and affirm the Referee's reasoning on this issue.

Compensability

The Referee found that claimant had not proven a compensable injury. We agree. A "compensable injury" is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability. ORS 656.005(7)(a). To establish a compensable injury, claimant must show that: (1) he injured himself in performing his job; and (2) the injury sustained was a material contributing cause of the resultant disability or need for medical services. The first element is a question of legal causation; the second concerns medical causation. Harris v. Farmers' Co-op Creamery, 53 Or App 618 (1981). Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981).

As the Referee noted, both legal and medical causation are at issue in the present case. For the following reasons, we conclude that claimant has not established either legal or medical causation sufficient to meet his burden of proof.

Claimant contends that he developed left ulnar neuropathy as a result of having struck his left elbow on a falling saw in January 1990. At hearing, claimant testified that, at the time he hit his elbow, he also burned his forearm attempting to catch the saw. Claimant demonstrated the scar at hearing, which the Referee and the parties agreed was approximately three to six inches long and two to three inches wide. Claimant testified that the burn caused him great pain, and subsequently blistered to one-quarter inch above the surface of his arm. However, claimant further testified that he did not seek medical treatment for the burn.

Claimant also stated that a supervisor and coworker witnessed the incident. Specifically, claimant testified that James Ronzoni, his coworker, witnessed the accident and was aware of the injury.

Because the Referee did not make a specific finding regarding claimant's credibility, we make our own credibility finding based on the substance of claimant's testimony, not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). We conclude that claimant has not credibly testified regarding the alleged work incident.

Here, claimant testified that he had had three other workers' compensation claims with the same employer and was aware of how to file a report following an injury. Yet, following the incident in January 1990, claimant did not file a claim for fifteen months.

Additionally, neither the medical records nor the remainder of the record establishes that claimant sustained such an injury at work. Claimant was treating with Dr. Teal for a carpal tunnel condition at the time he contends he was injured, yet he did not tell Dr. Teal about the injury for over a year. Claimant also saw Dr. Dreyer at some time following the injury, but did not inform Dr. Dreyer about his elbow problems or a burn on his left arm.

Moreover, although claimant argues that his coworker witnessed the accident and was aware of his injury, the coworker testified that he did not remember such an accident. In light of the severity of the accompanying burn described by claimant, we consider it unlikely that the coworker would have forgotten such an accident, had he witnessed the event. Additionally, although claimant contends that his supervisor was aware of the accident, the supervisor was not produced as a witness at hearing.

As a final point, we find claimant's testimony regarding the work incident to be suspect, as claimant had filed workers' compensation claims before, and thus understood the importance of promptly reporting such incidents. Although claimant testified that he did not report the injury because he was not in the habit of reporting every minor injury, we find that explanation to be inconsistent with claimant's description of the burn he sustained at the time the saw fell. Accordingly, we conclude that claimant has not established legal causation.

With regard to the medical evidence, we agree with the Referee that Dr. Teal's opinion is not persuasive, due to his failure to obtain a detailed history of the injury or work activities, the fact that he changed his position without explanation, and because Dr. Teal has not provided a reason for attributing claimant's condition to a blow on the elbow. More importantly, we note that both Dr. Teal and the Western Medical Consultants based their opinions on claimant's history of an elbow injury sustained at work. Because we have found that claimant is not credible, we conclude that the doctors' opinions based on claimant's history are entitled to little or no weight. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977). Thus, claimant has also failed to prove medical causation.

Because claimant has failed to prove both legal and medical causation by a preponderance of the evidence, we agree with the Referee that his injury claim is not compensable.

ORDER

The Referee's order dated November 2, 1993 is affirmed.

July 5, 1994 Cite as 46 Van Natta 1431 (1994)

In the Matter of the Compensation of
WILLIAM F. MACKEY, Claimant
WCB Case No. 93-03321
ORDER ON REVIEW
Nancy F. A. Chapman, Claimant Attorney
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Gunn.

The SAIF Corporation requests review of Referee Schultz's order that awarded claimant's attorney assessed attorney fees pursuant to ORS 656.386(1) and ORS 656.382(1). On review, the issues are attorney fees and penalties. We reverse the Referee's attorney fee award, but award a penalty under ORS 656.262(10).

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the first ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

Attorney Fee for Rescission of the Disclaimer of Responsibility

The Referee awarded claimant's attorney an assessed attorney fee for services rendered in obtaining a rescission of a disclaimer of responsibility pursuant to ORS 656.386(1). Under the circumstances of this case, we find that claimant's attorney is not entitled to an assessed fee pursuant to ORS 656.386(1).

Claimant argues that SAIF's disclaimer of responsibility was also a denial of his claim and, because his attorney was instrumental in having this "denial" rescinded prior to hearing, his attorney is entitled to an assessed attorney fee pursuant to ORS 656.386(1). We disagree with claimant that the disclaimer was also a denial of his claim.

On January 28, 1993, claimant filed a claim for a low back injury. (Ex. 30). It appears that SAIF received notification of this claim on February 1, 1993. Id. SAIF had 90 days within which to accept or deny that claim. ORS 656.262(6). On March 30, 1993, within the 90-day processing period, SAIF accepted the claim.

On March 2, 1993, prior to its acceptance, SAIF issued a disclaimer of responsibility, which stated that "[t]his is not a denial of your claim." (Ex. 34, emphasis in the original). Furthermore, the disclaimer stated that SAIF was continuing to investigate the compensability and responsibility of claimant's claim and that claimant would be notified of its final decision regarding those issues. Finally, the disclaimer contained the required notice paragraph pursuant to OAR 438-05-053(3) for a notice of intent to disclaim responsibility that is not a denial of the claim. Given the clear language of Exhibit 34, we find that it was not a denial of claimant's claim but was instead solely a disclaimer of responsibility.

This case is distinguishable from Johnny M. Davis, 45 Van Natta 2282 (1993). In Davis, the insurer issued a "disclaimer of responsibility" but also stated that it was not waiving other issues of "compensability" and included "notice of hearing" provisions consistent with a denial of compensation. OAR 438-05-053(4). Given the circumstances of that case, the Board determined that the insurer's "disclaimer" also created an issue concerning the compensability of the claimant's claim. On that basis, the Board agreed with the Referee's finding that the claimant's attorney was instrumental in securing the rescission of that compensability denial and the acceptance of the claim without a hearing. Accordingly, the Board found that the claimant was entitled to an insurer-paid attorney fee award under ORS 656.386(1).

Here, SAIF clearly identified the disclaimer as not being a denial of the claim. In addition, SAIF did not include any contradictory language that would indicate that the disclaimer was also intended to be a denial of compensability (e.g., a statement that it was not waiving any other issues of "compensability" or the inclusion of "notice of hearing" provisions consistent with a denial of compensation). Under such circumstances, SAIF's disclaimer of responsibility did not create an issue concerning the compensability of claimant's low back claim.

In Gamble v. Nelson International, 124 Or App 90 (1993), the court determined that a disclaimer of responsibility is not a denial, reasoning that a disclaimer serves only to notify the claimant that his or her claim may be compensable against another employer or insurer. Consequently, the court determined that the disclaimer neither triggered the provisions regarding the request for hearing under ORS 656.319 nor provided a basis for an attorney fee award under ORS 656.386(1) because the disclaimer did not create an issue concerning the compensability of the claim.

We have determined that SAIF's "disclaimer" was strictly that: a disclaimer of responsibility, which did not create an issue concerning the compensability of claimant's low back claim. Therefore, claimant's attorney is not entitled to an assessed fee under ORS 656.386(1). Gamble v. Nelson International, supra.

Attorney Fee for an Unreasonable Disclaimer of Responsibility

The Referee determined that the SAIF Corporation acted unreasonably in issuing the disclaimer of responsibility. However, because there were no amounts "then due" at the time of hearing upon which to base a penalty under ORS 656.262(10), the Referee awarded an assessed attorney fee pursuant to ORS 656.382(1) for SAIF's unreasonable conduct. We agree that the issuance of the disclaimer of responsibility was unreasonable. However, based on the following reasoning, we find that there are amounts "then due" during the relevant period upon which to base a penalty under ORS 656.262(10).

In 1979, claimant sustained a compensable injury with a prior employer which primarily injured his left elbow. (Exs. 1, 2, 3, 4). Subsequently, claimant became self-employed as a roofing contractor and purchased workers' compensation coverage through SAIF. Thereafter, claimant had a long history

of work-related low back injuries, which were accepted by SAIF. (Exs. 7, 8, 13, 13A, 14B, 16, 23, 24). On January 21, 1993, claimant sustained another work-related low back injury while lifting a ladder. (Exs. 29A, 30). The record contains no indication, medical or otherwise, that claimant's current low back injury was related to the 1979 elbow injury with the prior employer. Notwithstanding that fact, on March 2, 1993, SAIF issued a disclaimer of responsibility indicating that the 1979 injury may be responsible for claimant's current low back condition. (Ex. 34).

A penalty is assessable when a carrier unreasonably delays or unreasonably refuses to pay compensation. ORS 656.262(10). In determining whether a carrier's conduct is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of its conduct. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988).

Here, there is no evidence that would indicate that claimant's current low back condition was related to the 1979 elbow injury. In fact, SAIF makes no argument that its issuance of the disclaimer of responsibility was reasonable based on the information it had at the time it issued the disclaimer. Instead, it argues that it was required to issue a disclaimer of responsibility within 30 days if it believed another carrier was potentially responsible for claimant's condition.

ORS 656.308(2) provides, in relevant part, that "[a]ny employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim."

SAIF apparently argues that the 30 day deadline in ORS 656.308(2) forces it to issue a disclaimer of responsibility whenever the claimant has sustained a prior work-related injury while working for another carrier's insured. We disagree.

The statute does not require a carrier to issue a disclaimer of responsibility whenever there has been a previous work-related injury. Instead, such a disclaimer is required only when a carrier "intends to disclaim responsibility." We find that this language necessarily creates a reasonableness standard. To find otherwise leads to the illogical conclusion that the legislature encourages frivolous disclaimers of responsibility that have no factual, medical, or legal basis.

Here, the mere fact that claimant had a prior work injury to another body part, without more, does not provide a legitimate basis for a responsibility disclaimer. Accordingly, we find SAIF's disclaimer of responsibility unreasonable.

SAIF argues that, even if its conduct in issuing the disclaimer was unreasonable, there was no compensation due at hearing and, because all compensation had been timely paid, claimant was not entitled to an assessed attorney fee. SAIF relies on SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993), in support of its argument.

We find Condon distinguishable. Unlike the present case which involves an unreasonable disclaimer, Condon involved a claim that had neither been accepted nor denied within 90 days of the carrier's notification. In fact, the claim was not accepted until the date of the hearing, by which time all compensation had been paid. The Board found that the carrier's late acceptance constituted an unreasonable resistance to the payment of compensation and awarded an assessed attorney fee pursuant to ORS 656.382(1). The court reversed, holding that the carrier could not unreasonably resist the payment of compensation that had been paid.

We find Conagra, Inc. v. Jeffries, 118 Or App 373 (1993), more analogous to the present case. In Jeffries, the carrier unreasonably denied the claimant's claim. Subsequent to the hearing, but before the Referee had issued an order, the carrier accepted the claim by stipulation. The court held that, under these circumstances, penalties pursuant to ORS 656.262(10) were to be assessed on all compensation due at the time the denial was withdrawn.

Like Jeffries, this case is governed by ORS 656.262(10). Thus, the standard here is not whether SAIF unreasonably resisted payment of compensation, as was the case in Condon, supra, which applied ORS 656.382(1). Instead, the standard here is whether SAIF unreasonably delayed or refused to pay

compensation or unreasonably delayed acceptance or denial of a claim. ORS 656.262(10)(a). Furthermore, by unreasonably issuing a disclaimer of responsibility that had no factual, medical, or legal basis, SAIF unreasonably delayed payment of compensation and acceptance of claimant's claim.

Here, as discussed above, the disclaimer of responsibility is not a denial of compensability. However, like the denial in Jeffries, supra, the disclaimer was unreasonable. Even though SAIF ultimately accepted the claim within 90 days, that does not excuse the fact that it unreasonably disclaimed responsibility and thereby delayed payment of compensation until it rescinded that disclaimer and paid claimant's medical bills.

Applying the reasoning in Jeffries, penalties are due on the compensation due at the time of SAIF's March 30, 1993 acceptance. At that time, there were outstanding medical bills. (Ex. 54).

Accordingly, we assess penalties in the amount of 25 percent of the amounts "then due" at the time of the March 30, 1993 acceptance. The penalty is to be shared equally by claimant and his attorney. ORS 656.262(10)(a).

ORDER

The Referee's order dated September 27, 1993 is reversed. The assessed attorney fee awards are reversed. For the SAIF Corporation's unreasonable disclaimer of responsibility, claimant is awarded a 25 percent penalty based on the compensation due at the time of SAIF's March 30, 1993 acceptance, to be shared equally by claimant and his attorney.

Board Member Gunn dissenting in part.

I agree with the majority's assessment of a penalty under ORS 656.262(10). However, because I find that SAIF's March 2, 1993 document was more than a mere disclaimer of responsibility, I respectfully dissent from that portion of the majority's opinion that declines to assess an attorney fee under ORS 656.386(1).

ORS 656.262(1) provides that "[p]rocessing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer." That responsibility includes providing unambiguous documents to claimant regarding the compensability of his claim. Because Exhibit 34 is ambiguous, it does not meet that standard. The majority focuses on one sentence in this document, the statement that "[t]his is not a denial of your claim." However, the document must be read as a whole. When read as a whole, a reasonable person could easily read Exhibit 34 as including a denial of compensability.

A carrier must provide written notice of acceptance or denial of a claim within 90 days after the employer has notice or knowledge of the claim. ORS 656.262(6). However, a carrier may defer action on the claim while it is investigating the compensability of the claim, as long as acceptance or denial occurs within the mandated 90 days. Here, if SAIF was deferring action on this claim regarding the compensability issue, it should have clearly so stated. It did not. Instead, it provided an ambiguous document to claimant and then hid behind that ambiguity in order to deny claimant's attorney any fees for her work in getting the claim accepted without a hearing.

The entire range of workers' compensation benefits rides on whether a claim is compensable. Given the ambiguity presented by Exhibit 34, claimant was wise to seek legal counsel to pursue his rights. Furthermore, claimant's counsel's efforts resulted in the claim being accepted without a hearing. On that basis, I would award a reasonable attorney fee under ORS 656.386(1). For these reasons, I must respectfully dissent.

In the Matter of the Compensation of
SALLY BODMER, Claimant
WCB Case No. 93-09698
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Nichols' order that: (1) declined to award temporary disability; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties and attorney fees.

We adopt and affirm the Referee's order with the following supplementation.

Claimant asserts that the SAIF Corporation failed to raise claimant's removal from the workforce as an affirmative defense at hearing and is, therefore, barred from raising the "workforce" defense on Board review. We disagree.

Claimant requested a hearing on the grounds that she is entitled to total temporary disability. Inasmuch as claimant raised the issue of entitlement to temporary disability, she necessarily has the burden to prove that she was in the workforce during the relevant period. ORS 656.266. Additionally, even if claimant's voluntary removal from the workforce was not expressly raised as an affirmative defense, the hearing focused on claimant's willingness to work, her ability to work as demonstrated by her volunteer activities, and the alleged futility of a reasonable job search. As claimant did not object to the admission of evidence regarding whether she was in the workforce during the period for which she claims entitlement to temporary disability, we find the issue was raised at hearing. See Judith M. Morley, 46 Van Natta 882, 883 (1994) (Inasmuch as neither the claimant nor the insurer objected to the litigation of the compensability of the claimant's left wrist/forearm condition at hearing, the parties had raised the issue of compensability by implicit agreement).

Alternatively, claimant argues that her removal from the workforce was excused because a reasonable job search would have been futile. However, claimant's testimony that a job search would have been futile is not supported by any of the medical evidence.

Claimant voluntarily left her employment at injury in December of 1991. Claimant's treating physician, Dr. Thayer, explicitly stated that he did not authorize claimant to discontinue her employment at any time prior to her surgery in April of 1993. (Exs. 23-4, 38).

Furthermore, an earlier treating physician, Dr. Kendrick, M.D., received a telephone call from claimant on February 26, 1992. (Ex. 21-1). At that time, claimant conversed with Dr. Kendrick's staff (Karen Triplett, M.N.) about returning to work. Claimant felt that she was unable to work due to her left wrist condition. However, Dr. Kendrick states that he did not authorize claimant to discontinue her employment when this subject arose at an earlier appointment, and he still maintained that time loss was not indicated based upon claimant's medical condition. (Ex. 21-1).

Pursuant to that telephone conversation, claimant was examined by Dr. Kendrick on February 28. (Ex. 21-1). Dr. Kendrick notes that claimant had not been working for several months and was under the impression that Dr. Kendrick approved of her behavior. Dr. Kendrick recalls that claimant previously had mentioned that she could avail herself of an opportunity to take two or three weeks off of work, and Dr. Kendrick agreed that such a course of action might be beneficial. However, Dr. Kendrick never authorized claimant to leave work based on her left wrist condition; rather, he concluded that her behavior in remaining off work for several months was not reasonable. Dr. Kendrick stated: "I also would be very uncomfortable with authorizing time loss on a continuing basis." (Ex. 21-2).

Finally, claimant's testimony alone is insufficient to prove that a reasonable job search would have been futile. See Juana Piper, 45 Van Natta 553 (1993). Based on the foregoing reasoning, we conclude that claimant was not in the work force at the time of her need for medical treatment and that it would not have been futile for her to seek employment.

ORDER

The Referee's order dated November 30, 1993 is affirmed.

In the Matter of the Compensation of
AGAFIA H. BORU, Claimant
WCB Case Nos. 93-06857, 93-05449 & 93-03425
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Referee Daughtry's order that: (1) set aside SAIF's denial of claimant's aggravation claim for a neck, shoulder, right arm, and upper back condition; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new" occupational disease claim for the same condition; and (3) assessed an attorney fee against SAIF rather than Liberty. On review, the issues are compensability, responsibility, aggravation, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

The Referee found that SAIF's 1989 acceptance of claimant's "cervical and upper thoracic strains" included claimant's neck, upper back, shoulder, and right arm pain. Accordingly, finding no evidence that claimant suffered a new injury or occupational disease after 1989, the Referee concluded that under ORS 656.308(1) SAIF remains responsible for claimant's current neck, shoulder, arm and upper back condition. On review, SAIF contends that its acceptance does not include claimant's current complaints, because Liberty, rather than SAIF, is responsible for claimant's new occupational disease. We agree with the Referee's conclusion; however, we offer the following analysis.

As a preliminary matter, we do not agree with the Referee's comment that SAIF's formal acceptance included all body parts and conditions mentioned in claimant's treatment records before and shortly after SAIF issued its Notice of Acceptance. See Johnson v. Spectra Physics, 303 Or 49 (1987) (acceptance of a claim encompasses only those conditions specifically or officially accepted in writing). Rather, we find that claimant's neck, upper back, shoulder, and right arm pain are and were manifestations of the conditions SAIF accepted. Our order should not, therefore, be interpreted as expanding the scope of SAIF's acceptance.

Claimant sought treatment from Dr. Selby in November 1989 for neck, shoulder, and right arm pain. Dr. Selby noted muscle spasm and limited cervical, shoulder, and thoracic ranges of motion. Dr. Selby attributed claimant's neck, shoulder, upper back, and right arm symptoms to cervical and thoracic spine strains. Accordingly, because SAIF accepted claimant's cervical and upper thoracic strains, we agree with and adopt the Referee's reasoning and conclusion that claimant has established, by objective findings supported by medical evidence, that her current neck, shoulder, right arm, and upper back condition and need for treatment are compensably related to the conditions SAIF accepted.

Since we have found the condition compensable, the question remains whether claimant sustained an aggravation of her compensable conditions or a new occupational disease, and if she did, whether it arose while SAIF or Liberty was on the risk. (Claimant worked for the same employer between March 1987 and March 1993. SAIF was on the risk through March 31, 1990. Thereafter, Liberty was on the risk).

ORS 656.308 encompasses occupational disease claims. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993); Donald C. Moon, 43 Van Natta 2595, 2596 n. 1 (1991). To establish a "new" occupational disease, the carrier with the accepted claim has the burden of establishing that the claimant's subsequent work activities were the major contributing cause of the claimant's current condition. See ORS 656.802(2); SAIF v. Drews, 318 Or 1 (1993). As the insurer with the accepted 1989 claim, SAIF has the burden of proof. Accordingly, to establish that claimant sustained a new occupational disease after 1989, SAIF must prove that claimant's subsequent work activities were the

major contributing cause of claimant's current neck, shoulder, right arm, and upper back condition. We conclude that SAIF has not carried its burden of proof.

Here, the medical evidence is uncontroverted that claimant's 1989 injury with SAIF remains the major contributing cause of claimant's current disability and need for treatment. Dr. Winans, claimant's former treating osteopathic physician, opined that the symptoms for which he treated claimant from July 1992 through February 1993 were "directly related to injuries sustained on November 8, 1989, rather than a new incident." Dr. Mitchell, claimant's current treating physician, noted that the condition for which he began treating claimant in March 1993 was a continuation of the "same problem that she had in 1989." There is no medical or testimonial evidence to the contrary.

We find, therefore, that SAIF has not proved that claimant sustained a new occupational disease. Accordingly, responsibility for claimant's current neck, shoulder, right arm, and upper back condition remains with SAIF. See ORS 656.308(1); Drews, supra.

Aggravation

Having found that claimant did not sustain a new occupational disease, we next determine whether claimant sustained a compensable aggravation. We adopt the Referee's reasoning and conclusion that claimant established a compensable aggravation of her accepted SAIF claim, with the following comment.

On review, SAIF argues that claimant's assignment to modified work in 1992 does not necessarily constitute a compensable aggravation. We agree. See ORS 656.273; Fred Meyer, Inc., v. Farrow, 122 Or App 164 (1993) (an aggravation of an unscheduled injury is measured by increased loss of earning capacity). That, however, is not what the Referee found. Rather, after noting that claimant performed regular work up until she was given modified work in July 1992, the Referee specifically recited that claimant did not work after March 1993, when lighter work was no longer available. It was this loss of modified work in March 1993 that established claimant's loss of earning ability and constituted a worsening of her compensable condition.

Therefore, we agree with and adopt the Referee's reasoning and conclusion that the opinions of Drs. Davies, Winans, and Mitchell establish that claimant's accepted condition has worsened since 1989, and that her current disability and need for treatment are supported by objective findings.

Attorney Fees

The Referee, after finding claimant's aggravation claim compensable, ordered SAIF to pay an assessed attorney fee of $3,000. On review, SAIF asserts that, because Liberty denied claimant's claim, the Referee erred in awarding claimant an assessed attorney fee payable by SAIF. Liberty responds that since responsibility remains with SAIF, the Referee did not err in holding that the attorney fees were payable by SAIF.

SAIF denied compensability of claimant's aggravation claim. Both SAIF and Liberty denied compensability of and responsibility for claimant's new occupational disease claim. Although we do not disturb the Referee's finding that claimant did not sustain a new occupational disease claim while either SAIF or Liberty was on the risk, we have herein affirmed that claimant's neck, shoulder, right arm, and upper back condition is compensable as an aggravation of claimant's accepted occupational disease claim with SAIF. Consequently, SAIF is responsible for the attorney fee assessed at hearing. ORS 656.386(1).

In addition, claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the denial issues is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to these issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 19, 1993 is affirmed. For services on review, claimant's counsel is awarded $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
STEVEN W. COONS, Claimant
WCB Case No. 93-13295
ORDER ON REVIEW
Peter J. Carini, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Brazeau's order that upheld the SAIF Corporation's denial of his claim for a myocardial infarction. On review, the issue is compensability. We affirm.

We adopt and affirm the Referee's order with the following supplementation.

Claimant argues that the Referee erred when he concluded that Drs. DeMots and Wysham were "essentially in agreement with one another, i.e., that the major contributing cause of claimant's myocardial infarction was his pre-existing and underlying arterial disease." (O & O p.4). We disagree.

Claimant has preexisting coronary artery disease which allegedly combined with work activity to produce a myocardial infarction. Therefore, in order to establish a compensable injury, claimant must prove that the work activity was the major contributing cause of his myocardial infarction. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993).

Dr. DeMots, Professor and Head of the Division of Cardiology at the Oregon Health Sciences University, examined claimant and stated that the "major contributing cause of [claimant's] infarction was the pre-existing coronary artery disease which in turn was related to his elevated cholesterol and to some extent his elevated blood pressure." (Ex. 9). In a later report, Dr. DeMots reviewed articles from the New England Journal of Medicine submitted by claimant that discussed the relationship between heavy exertion and myocardial infarctions. Dr. DeMots reported:

> "These articles, which appeared subsequent to my report do not sway me in my opinion that the major contributing cause of infarction is the underlying coronary artery disease, which in turn is related to the risk factors described in my previous report. Based on my conversations with the Harvard group headed by Jim Muller the authors of the appear (sic) would not disagree with that position. * * *
>
> "Neither article purports to show that exercise is the cause of infarction and only shows results which support the hypothesis that exercise is one of many 'triggers' for infarction. * * *
>
> "In a careful reading of the two reports the word cause is not used and there is no representation that exercise causes myocardial infarction. The cause of myocardial infarction has been shown to be the result of the progression of atherosclerosis which eventually leads to plaque rupture. The causes of plaque rupture are multifactorial * * *." (Ex. 14).

Dr. Wysham, a cardiologist who had examined claimant, reported:

> "The cause of [claimant's] heart attack most likely was the rupture of an atherosclerotic plaque in his anterior descending coronary artery, with a secondary thrombosis resulting in occlusion of this artery. The underlying cause, therefore, was atherosclerotic heart disease. The precipitating factor or triggering of his acute myocardial infarction was most likely related to the heavy physical exertion including isometric activity, or lifting heavy objects, during the half hour or so prior to the onset of his myocardial infarction." (Ex. 15; emphasis added).

After reviewing Dr. DeMots' second report, Dr. Wysham stated:

> "To comment specifically on Dr. DeMots' letter of December 24, 1993: I agree with him that underlying coronary artery disease is, in almost all cases, the major contributing cause of acute myocardial infarction. The only exceptions I can think of to this rule are the rare cases of myocardial infarction caused by coronary spasm. However, in most of these medical-legal cases we are not concerned about the underlying cause of coronary artery disease, even if it is the major cause, but about the factors which may have precipitated the particular myocardial infarction which is in question." (Ex. 16; emphasis added).

Dr. Wysham concluded that "there is reason to believe that [claimant's] physical activity just prior to his myocardial infarction should be considered a significant precipitating factor." (Id).

The issue is whether claimant's work activity was the major contributing cause of his myocardial infarction. Dr. DeMots reported that the major contributing cause of claimant's myocardial infarction was his underlying coronary artery disease. (Ex. 9). Dr. Wysham agreed with Dr. DeMots that coronary artery disease is "in almost all cases, the major contributing cause of acute myocardial infarction." (Ex. 16). Dr. Wysham noted that there is one exception, rare cases of myocardial infarction caused by coronary spasm. Dr. Wysham did not indicate that claimant fell into that category. Although Dr. Wysham said that claimant's work activity was a "significant precipitating factor" in his myocardial infarction, he concluded that the "underlying cause of the myocardial infarction in [claimant's] case was atherosclerotic coronary disease." (Exs. 15 & 16).

According to our interpretation of Dr. Wysham's opinions, he agrees with Dr. DeMots that the major contributing cause of claimant's myocardial infarction was his coronary artery disease. We find Dr. DeMots' opinion, as supported by Dr. Wysham, to be persuasive. We agree with the Referee's conclusion that the medical evidence establishes that, although claimant's work activities were a significant factor in triggering his myocardial infarction, the major cause was the underlying coronary artery disease. Because claimant has not met his burden of proof, we conclude that his claim is not compensable.

ORDER

The Referee's order dated March 1, 1994 is affirmed.

July 7, 1994 Cite as 46 Van Natta 1439 (1994)

In the Matter of the Compensation of
DENNIS ENTRIKEN, Claimant
WCB Case No. 93-11521
ORDER ON REVIEW (REMANDING)
Welch, Bruun, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

The insurer requests review of Referee Lipton's stipulated order in which claimant dismissed his hearing request from the insurer's denial of claimant's right knee injury claim because the insurer had accepted the claim pursuant to the stipulation. The insurer seeks remand for the development of a record concerning its contention that the underlying claim was fraudulent. We grant the request for remand.

The Board has discretionary authority to remand cases when, in its judgment, it finds the record to be improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, the moving party must establish that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Here, the insurer contends that it obtained information that the underlying claim was fraudulent after the stipulation was approved. In light of this information, within 30 days of the Referee's approval of the stipulation, the insurer asked the Referee to rescind the stipulation or, alternatively, to abate the stipulation pending a decision on its motion to rescind. The Referee declined to abate or rescind the stipulated order until the insurer submitted an affidavit attesting to evidence regarding the alleged fraudulent claim.

The insurer then requested Board review, seeking remand for the development of a record concerning its contentions. On review, claimant argues that the insurer is not entitled to this extraordinary relief because it failed to exercise due diligence in protecting its rights by presenting additional evidence to the Referee, filing a hearing request, or issuing a "back-up" denial under ORS 656.262(6).

The Board has found remand to be appropriate in similar situations. In Mary A. Summers, 42 Van Natta 2393 (1990), the Board remanded a Disputed Claim Settlement to the referee for development of a record from which to evaluate the claimant's contention that the settlement was entered into based on misrepresentation, duress, and/or mistake. The Board took a similar approach in Edwin L. Carson, 43 Van Natta 107, on recon 43 Van Natta 835 (1991). There, the Board remanded a stipulated order to the referee to develop a record from which to determine whether the claimant understood the terms of the stipulation and assented to those terms.

In both Summers and Carson, no hearing had been convened and no evidence admitted. Thus, there was no record upon which to resolve the issue raised on review. That is also the situation in the present case. We conclude that remand is equally appropriate here.

In reaching this decision, we reject claimant's contention that remand is not appropriate because the insurer failed to request a hearing. We are aware of prior Board cases holding that a hearing request is the proper vehicle for challenging a settlement. See Lawrence Woods, 34 Van Natta 1671 (1982) (hearing request, rather than Board review, is proper remedy for challenging disputed claim settlement). See also Ann M. Ryan, 39 Van Natta 774 (1987) (referee order approving disputed claim settlement is not an appealable order). However, in the Carson and Summers decisions discussed above, the Board has more recently accepted review and remanded such cases to the referee approving the settlement at issue. In other words, the rationale expressed in Ryan and Woods has been essentially disavowed.

We conclude that the Carson/Summers rationale is the better approach, regardless of whether the challenged settlement is a Disputed Claim Settlement or a stipulation. A referee's order approving either type of settlement results in dismissal of a hearing request and is a final, appealable order. Glen D. Roles, 42 Van Natta 68, 72 (1990) (order dismissing hearing request is final, appealable order notwithstanding the fact the order did not set forth parties' appeal rights).

Moreover, in remanding this case to the Referee, the Board is not vacating the stipulation. We are, instead, allowing the Referee to develop a record and rule on the validity of the stipulation. Upon remand, the parties will be in the same position they would have been in if the insurer had requested a hearing. Accordingly, we conclude that the insurer's failure to request a hearing does not bar remand to the Referee.

Nor are we persuaded that the insurer did not exercise due diligence in not resubmitting the matter to the Referee with the requested affidavit. The insurer's decision to request Board review in this case was understandable given the Referee's decision not to abate the order pending receipt of the requested affidavit. Absent an abatement, the insurer risked expiration of the 30-day appeal period without a favorable ruling by the Referee. See ORS 656.289(3); Geer v. SAIF, 121 Or App 647 (1993).

Moreover, as noted above, the stipulation at issue here dismissed a request for hearing and was a final, appealable order. There is no requirement that a party request reconsideration from a referee's final order before appealing that order to the Board. See ORS 656.289; OAR 438-07-025.

Finally, we are not persuaded by claimant's argument that the insurer should have issued a "back-up" denial of claimant's right knee injury claim. The court has recently concluded that a "back-up" denial of a claim accepted by stipulation is not authorized under ORS 656.262(6). Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). But see Sperry, Inc. v. Wells, 127 Or App 700 (1994) (stipulation constituted an acceptance where Board's finding reaching such a conclusion was uncontested). The validity of a "back-up" denial in this case is questionable in light of the Fimbres decision. Accordingly, we conclude that remand is not precluded by the insurer's decision not to issue a possibly invalid "back-up" denial.

In summary, we conclude that the insurer exercised due diligence in petitioning the Board for remand in this case. Accordingly, this matter is remanded to Referee Lipton with instructions to conduct further proceedings at which time the parties will be permitted to submit evidence and argument regarding the issues raised by the insurer's appeal. Those proceedings may be conducted in any manner that the Referee determines achieves substantial justice.

Should the Referee determine that the insurer did not enter into the stipulation based on the fraudulent grounds alleged by the insurer, the Referee shall issue a final, appealable order adhering to the stipulated order. In the event that the Referee finds that the stipulation was entered into based on the fraudulent grounds alleged by the insurer, the Referee shall issue an interim order vacating the stipulated order. Thereafter, the Referee shall reinstate claimant's hearing request and schedule the case for hearing on the merits of that request. (The Referee shall also have the discretion to conduct a "consolidated" hearing that includes both the "fraudulent claim" issue, as well as the alternative "compensability" issue). Following the hearing on the merits, the Referee shall issue a final, appealable order incorporating the interim order.

IT IS SO ORDERED.

Board Member Gunn specially concurring.

I agree with the majority's disposition of this case. I write only to clarify the employer's burden of proof on remand. Specifically, it is my position that the employer must prove that its acceptance under the stipulation was induced by fraud, misrepresentation or other illegal activity. Bauman v. SAIF, 295 Or 788, 794 (1983); Tony N. Bard, 45 Van Natta 1224 (1993).

In the Matter of the Compensation of
NANCY S. JENKS, Claimant
WCB Case No. 93-07703
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee McWilliams' order which denied her request for an insurer-paid attorney fee under ORS 656.386(1) for finally prevailing without a hearing against the insurer's "de facto" denial of several conditions which the insurer had not previously specifically accepted. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On July 8, 1988, the insurer issued a Notice of Claim Acceptance for a midback strain/sprain. During subsequent years, claimant received treatment for several other conditions that had not been specifically accepted. On June 28, 1993, claimant filed a request for hearing alleging a "de facto" denial of conditions not specifically accepted by the insurer. On the day before the scheduled hearing, and more than 90 days after it had notice of the conditions in question, the insurer issued an "Amended Notice of Acceptance" to include all conditions for which medical benefits had been paid.

The parties proceeded to hearing on the issue of claimant's entitlement to a carrier-paid attorney fee under ORS 656.386(1). Although she found that compensability of the conditions included in the amended notice of acceptance was at issue by reason of the insurer's "de facto" denial, the Referee, nevertheless, concluded that claimant was not entitled to an assessed attorney fee under ORS 656.386(1). Specifically, the Referee determined that, for the statute to be applicable, there had to be a dispute as to causation. Inasmuch as the insurer had paid all medical bills, the Referee found that there was no dispute as to causation. Thus, according to the Referee, claimant was not entitled to an assessed attorney fee.

On review, claimant contends that she is entitled to an assessed attorney fee for her counsel's efforts in obtaining rescission of the "de facto" denial. We agree.

We have recently held that, when a claimant's attorney is instrumental in obtaining rescission of a "de facto" denial shortly before or at a hearing, claimant is entitled to a carrier-paid attorney fee pursuant to ORS 656.386(1). See Barbara J. Fuller, 46 Van Natta 1129 (1994); Wesley R. Craddock, 46 Van Natta 713 (1994). Likewise, in this case, claimant's attorney filed a request for hearing that resulted in the rescission of the insurer's "de facto" denial of the conditions listed in the amended acceptance notice. Accordingly, claimant is entitled to an assessed attorney fee under ORS 656.386(1). Barbara J. Fuller, supra; Wesley J. Craddock, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services in obtaining rescission of the "de facto" denial is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered those services leading to the insurer's acceptance of the omitted conditions (based on the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 1, 1993 is reversed. Claimant's attorney is awarded an assessed attorney fee of $500, payable by the insurer.

In the Matter of the Compensation of
JEROME D. McINTYRE, Claimant
WCB Case No. 92-06864
ORDER ON REVIEW
Dennis V. Messoline, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Mongrain's order that dismissed his hearing request as untimely filed. On review, the issue is timeliness. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and the Referee's first ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not shown good cause for failing to timely file his hearing request from the SAIF Corporation's denial. We agree and adopt the Referee's conclusion and reasoning concerning the timeliness issue with the following supplementation.

A request for hearing must be filed no later than the 60th day after a claimant is notified of a denial. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial confers jurisdiction if the claimant has good cause for the late filing. ORS 656.319(1)(b).

There is no dispute that claimant filed his hearing request 61 days after he was notified of SAIF's denial. The only dispute on review is whether claimant has established good cause for filing his hearing request more than 60 days after notification of the denial.

In support of his contention that he had good cause for failing to timely request a hearing, claimant contends that he did not file a timely hearing request on SAIF's denial because he believed that he would be vindicated by a separate administrative proceeding which might have resulted in reinstatement to his job. On this basis, claimant contends that his delay in filing a hearing request was excusable mistake or neglect because he believed the other proceeding would render a workers' compensation proceeding unnecessary. We disagree.

Claimant's choice to pursue a remedy in a different area of the law in lieu of pursuing a remedy under workers' compensation law does not constitute good cause for failing to timely request a hearing under ORS 656.319(1)(b). In this regard, we have previously held that a claimant's choice to pursue an alternative remedy did not constitute "good cause" under ORS 656.319. See Michael F. May, 42 Van Natta 1308 (1990) (A claimant's choice to pursue an aggravation claim in another state did not constitute good cause for a failure to timely file a hearing request).

Accordingly, we affirm the Referee's conclusion that claimant has not established good cause for his failure to timely file his request for hearing. Because we find that claimant's hearing request on SAIF's denial is untimely, we do not address the merits of the claim.

ORDER

The Referee's order dated July 27, 1993, as amended on July 29, 1993 and reconsidered on August 26, 1993, is affirmed.

July 7, 1994 Cite as 46 Van Natta 1443 (1994)

In the Matter of the Compensation of
JERRY R. TESTERMAN, Claimant
WCB Case No. 93-08773
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Menashe's order that: (1) dismissed as untimely claimant's hearing request concerning the insurer's March 24, 1993 denial of claimant's claim for a right leg and lower back condition; and (2) alternatively upheld the insurer's denial. Based on a recent Board order affirming a prior referee's dismissal order, the insurer moves that the Board dismiss claimant's request for Board review. On review, the issues are motion to dismiss, timeliness of the hearing request and compensability.

We deny the motion to dismiss and adopt and affirm the Referee's order with the following supplementation.

Claimant, through his former attorney, timely requested a hearing regarding the insurer's March 24, 1993 denial of claimant's claim for a right leg and lower back condition. That hearing request was designated as WCB Case No. 93-04408. On July 7, 1993, that hearing convened. Claimant was present at the July 7, 1993 hearing and was represented by his former attorney, who requested that claimant's hearing request be dismissed. As a result of that request, the prior Referee issued an Order of Dismissal on July 20, 1993. After reconsideration, the prior Referee continued to find dismissal appropriate and declined to grant claimant's post-hearing request for postponement.

Claimant ultimately requested review of that Order of Dismissal, contending that he should have been granted an evidentiary hearing to determine whether he understood and authorized his former attorney's actions in requesting dismissal. In the alternative, claimant contended that his post-hearing request for postponement of the hearing should have been granted. In Jerry R. Testerman, 46 Van Natta 1114 (1994), we rejected claimant's contentions, declined to remand for an evidentiary hearing regarding the earlier dismissal, and found both the dismissal and the postponement denial appropriate.

After the July 7, 1993 hearing, claimant sought the advice of another attorney. On July 28, 1993, claimant's current attorney requested a hearing again on the March 24, 1993 denial. It is this subsequent hearing request that is the subject of the current litigation. (WCB Case No. 93-08773).

As a preliminary matter, the insurer requests that we dismiss claimant's request for Board review in light of our recent decision in Jerry R. Testerman, supra. The insurer argues that our earlier decision renders the current matter moot. We disagree.

Both hearing requests pertained to claimant's appeal of the insurer's March 24, 1993 denial. Nevertheless, the issues in the two cases are quite different. The issues presented in the earlier case involved the propriety of the July 20, 1993 dismissal order and the prior Referee's refusal to grant a post-hearing request for postponement of the July 7, 1993 hearing. The issue presented in the current case is whether claimant has established good cause for his untimely filing of the subsequent July 28, 1993 hearing request from the March 24, 1993 denial. This issue was not raised in the earlier case. Therefore, the earlier decision does not render the current matter moot. In addition, claimant timely requested review of Referee Menashe's order. See ORS 656.289(3); ORS 656.295(2). Inasmuch as that order has not become final, the issues pertaining to that decision remain viable. Under these circumstances, we find no reason to dismiss claimant's request for Board review of that order.

As to the current matter, a request for a hearing must be filed not later than the 60th day after claimant is notified of a denial of a claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B or former ORS 18.160. Naught v. Gamble, Inc., 87 Or App 145 (1987); Brown v. EBI Companies, 289 Or 455 (1980).

The July 28, 1993 request for hearing was filed more than 60 days but within 180 days after receipt of the denial. Claimant argues that he has established good cause for the late filing of his hearing request. We disagree.

At the time of the July 7, 1993 hearing, an expected medical report had not yet been received by claimant or his former attorney. However, claimant understood that his former attorney would go forward with the hearing or request a postponement to await the medical report. Instead, at the scheduled hearing, his former attorney requested that the hearing request be dismissed.

Claimant argues that his former attorney's request for dismissal at the prior hearing was a surprise to him. In addition, he argues that his former attorney's allegation that claimant had assessed his chances of prevailing and had decided to dismiss his case was either a mistake on the part of his former attorney or an outright misrepresentation. In short, claimant argues that his former attorney erred or was negligent in requesting that the earlier hearing request be dismissed, thus establishing good cause for claimant's subsequent untimely hearing request.

Even if claimant's former attorney was negligent in requesting dismissal of the earlier hearing request, the negligence of an attorney is not excusable neglect unless the attorney's reason for his action would be excusable had it been attributed to claimant. Sekermestrovich v. SAIF, 280 Or 723 (1977); see also Mendoza v. SAIF, 123 Or App 349 (1993) (neglect of an attorney's employee, who was responsible for filing the hearing request, is not excusable neglect). Here, the reason for the former attorney's action in requesting dismissal was his assessment of the success of claimant's claim on the evidence in the record. Such a reason would not constitute excusable neglect if attributed to claimant. On this record, claimant has not established good cause for his untimely hearing request.

Finally, we agree with claimant's argument that the July 20, 1993 Order of Dismissal was without prejudice, because it did not specifically state that it was a dismissal with prejudice. Julie Mayfield, 42 Van Natta 871 (1990). However, the fact that the dismissal was without prejudice does not help claimant under the circumstances of this case. Although a dismissal without prejudice does not prevent the reraising of issues, those issues must be reraised within the time limits set out by ORS 656.319. Ralph B. DePaul, 44 Van Natta 92 (1992); Claudia I. Hamilton, 42 Van Natta 600 (1990). Here, since claimant's hearing request was filed more than 60 days after the March 24, 1993 denial, claimant did not reraise the issues within the time limits set out by ORS 656.319. Furthermore, claimant failed to establish good cause for his subsequent untimely hearing request.

ORDER

The Referee's order dated November 16, 1993 is affirmed.

In the Matter of the Compensation of
FRANK M. DOUGLAS, Claimant
Own Motion No. 66-0207M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Dennis O'Malley, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's February 17, 1994 Notice of Closure, which closed his claim with an award of temporary disability compensation from June 10, 1991 through February 4, 1994. SAIF declared claimant medically stationary as of January 19, 1994. Claimant contends he is entitled to additional temporary disability compensation as he was not medically stationary when his claim was closed.

As a preliminary matter, we note that claimant requests that this case be referred to the Hearings Division for a fact-finding hearing regarding the issue of his medically stationary status. We do not find that the record is inadequately developed to determine the issue before us; therefore, we decline to grant claimant's request.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the February 17, 1994 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

On July 4, 1960, claimant sustained a compensable injury to his right leg which ultimately resulted in an above-knee amputation. Because claimant's industrial injury occurred prior to January 1, 1966, claimant does not have a right under ORS 656.245 to lifetime medical services for his compensable injury. The Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. In addition, we may authorize the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. See ORS 656.278(1)(a).

In May 1991, claimant's claim was reopened under the Board's own motion authority to provide further medical services related to the 1960 injury, including surgery.

On January 19, 1994, Dr. Gripekoven, claimant's treating physician, opined that from the standpoint of claimant's surgical intervention, "I feel that he now could be considered medically stationary." He added that "[i]t is important, however, that [claimant] will need ongoing, lifetime medical followup for supervision of his stump and for prosthetic fitting as necessary." By letter dated February 2, 1994, Dr. Gripekoven explained that he considered his January 19, 1994 evaluation of claimant to be a closing evaluation. He reiterated that claimant will need ongoing care for his prosthesis, but stated that claimant does not currently need active orthopedic treatment. Finally, Dr. Gripekoven recommended permanent job modification for claimant in order to avoid constant standing. Based on Dr. Gripekoven's opinion, SAIF issued the February 17, 1994 Notice of Closure, which closed claimant's claim with a medically stationary date of January 19, 1994.

Although claimant agrees that no further surgery is expected to improve his condition, he argues that his claim was prematurely closed because he has not received a prosthesis that will enable him to stand or walk for very long. Claimant argues that his work requires him to be on his prosthesis at least eight hours a day and that he is unable to do that without a better prosthesis.

By letter dated June 6, 1994, Mr. Jansen, C.P., stated that claimant was in the process of being fitted for a new prosthesis. Mr. Jansen stated that "[a]t present there seems to be definate [sic] progress, but only time will tell if all the difficulties have been addressed. At this time [claimant] is not prosthetically stable in this prosthetic fitting."

Essentially, claimant is arguing that he is not medically stationary because, although his physical condition will not improve over time or with further medical treatment, his functional ability will be improved with treatment in the form of a better prosthesis. This argument is supported by Mr. Jansen's report.

Claimant makes a compelling argument. However, the court rejected this argument in Clarke v. SAIF, 120 Or App 11 (1993). There, the claimant's compensable low back injury required surgery. On June 16, 1989, the treating physician declared the claimant medically stationary, although noting permanent weakness in the claimant's right leg. The claimant's claim was closed with a medical stationary date of June 16, 1989. The treating physician prescribed a leg brace to support the claimant's weak leg. On March 27, 1990, the treating physician approved the final fit of the leg brace and released the claimant from further treatment. The claimant argued that he was not medically stationary until March 27, 1990, the date of his final fitting and release from medical care.

In Clarke, the court paraphrased the claimant's argument as an argument that "ORS 656.005(17) is not limited to medical treatment prescribed for improving his physical condition, but also encompasses treatment prescribed solely for the improvement of his functional abilities given a particular condition." Clarke v. SAIF, supra at 120 Or App 13. The court rejected that argument and held that "medical treatment prescribed solely to improve a claimant's functional abilities is not pertinent to the determination of a claimant's medically stationary date under ORS 656.005(17)." Id. at 120 Or App 13-14. Because there was no evidence that the leg brace was prescribed to improve the claimant's physical condition, the court concluded that claimant was medically stationary on June 16, 1989.

Here, a better prosthesis will improve claimant's functional abilities. However, functional improvement alone is not pertinent to the determination of claimant's medically stationary status. The deciding factor is that there is no evidence that a new prosthesis was prescribed to improve claimant's physical condition, i.e., the condition of claimant's amputation stump. Without such evidence, and given Dr. Gripekoven's unrebutted opinion that claimant was medically stationary as of January 19, 1994, we find that claimant was medically stationary on that date.[1] Therefore, we conclude that SAIF's closure was proper. Accordingly, SAIF's February 17, 1994 Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

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[1] We note that, on May 18, 1994, SAIF requested authorization to reopen claimant's claim for the provision of medical services. These medical services include claimant's travel expenses to the Oregon Artificial Limb Co., Inc. Claimant argues that SAIF's request for reopening for medical services "is essentially an acknowledgement that [claimant] is not stable at this time." Even if claimant's characterization of SAIF's request is correct, it does not support claimant's argument that his claim was prematurely closed.

The relevant inquiry is whether claimant was medically stationary at claim closure. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., supra; Alvarez v. GAB Business Services, supra. Thus, a subsequent request for reopening does not, in itself, establish that claimant was not medically stationary at claim closure.

In the Matter of the Compensation of
LEONA M. BROOKS, Claimant
WCB Case No. 93-03591
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of that portion of Referee Daughtry's order that awarded a penalty for an allegedly unreasonable discovery violation. In her respondent's brief, claimant contends that penalties are justified by the employer's alleged discovery violation, as well as its allegedly unreasonable denial. On review, the issues are penalties and attorney fees.

We adopt and affirm the Referee's order with the following supplementation and modification.

The employer concedes that it failed to timely provide claimant with a copy of a cover letter sent to Dr. Neufeld on April 27, 1993. (Ex. 18-B). However, the employer argues that its failure to disclose the letter was not unreasonable because all the relevant claim information contained in that cover letter was disclosed in Dr. Neufeld's subsequent reply of May 10, 1993 -- which was timely provided to claimant. (Ex. 19). The employer contends that the Referee erred in finding its actions unreasonable and awarding a penalty pursuant to ORS 656.262(10). We disagree.

The relevant discovery rules provide that all documents pertaining to a claim shall by disclosed within 15 days of a Request for Hearing or a written request for discovery. OAR 438-07-015(2). All documents acquired after the initial exchange shall be disclosed within 7 days after the disclosing party's receipt of the documents. OAR 438-07-015(4). Failure to comply with this rule shall, if found unreasonable, be considered delay or refusal under ORS 656.262(10). OAR 438-07-015(5).

Claimant requested a hearing on March 22, 1993. The employer was obligated to make the initial exchange of discovery materials by April 6, 1993. Any further relevant documents received by the employer after the initial discovery should have been mailed to claimant within 7 days. The employer generated the cover letter to Dr. Neufeld on April 27, 1993. (Ex. 18B-1). Accordingly, the employer should have provided a copy of the cover letter to claimant no later than May 4, 1993. However, the cover letter was not made available to claimant until June 14, 1993. (Id).

Furthermore, claimant made a specific written request for discovery. The written request was made pursuant to a letter sent to the employer on May 24, 1993, wherein claimant specifically requested the cover letter to Dr. Neufeld. (Ex. 22). The employer did not respond to claimant's request. Claimant renewed his request at the June 10, 1993 hearing and ultimately received a copy of the cover letter four days later. (Ex. 18B-1)

The Referee reasoned that, since the examination by Dr. Neufeld was conducted on May 10, 1993, the employer's unexplained failure to provide the cover letter which elicited that examination until June 14, 1993, was unreasonable. Consequently, the Referee assessed a penalty pursuant to ORS 656.262(10).

We agree that the employer's delay in providing discovery was unreasonable and that a penalty was properly assessed pursuant to OAR 438-07-015(5). Regardless of whether the cover letter to Dr. Neufeld contained identical claims information as the other documents disclosed to claimant, we find the employer's action to be unreasonable.

Specifically, the employer's unreasonable behavior is evidenced by: (1) its failure to provide full disclosure of a document relevant to a claim within 7 days of its creation by the employer; and (2) failure to provide disclosure of the same document within 7 days of a written request for discovery. See OAR 438-07-015(2), (5); Mickey L. Wood, 40 Van Natta 1860, 1866 (1988). The employer does not argue that the cover letter was not a document pertaining to the claim under OAR 438-07-015. Accordingly, the employer's unreasonable failure to timely provide discovery justifies the assessment of a penalty pursuant to ORS 656.262(10). OAR 438-07-015(5).

Finally, at hearing and on Board review, claimant alleges two separate instances of unreasonable conduct on the part of the employer. The first unreasonable act was the aforementioned discovery violation which gave rise to a penalty under ORS 656.262(10). The second instance of unreasonable claims processing was the employer's March 12, 1993 unreasonable denial of claimant's right shoulder condition. (Ex. 16).

The Referee reasoned that the employer had no legitimate doubt as to the compensability of claimant's right shoulder condition and carpal tunnel syndrome after May 10, 1993. The employer does not contest that finding.

We agree with the Referee's reasoning, but note that the Referee implied that the employer had knowledge as to the conclusions reached by Dr. Neufeld as of May 10; Dr. Neufeld examined claimant at the employer's request. While the examination was conducted on May 10, the record reveals that the employer was not in receipt of Dr. Neufeld's medical opinion until May 21. (Ex. 19-1). Therefore, we find that the self-insured employer's denial of claimant's right shoulder and arm condition was no longer reasonable after May 21, 1993.

Reasoning that he was precluded from assessing a double penalty for the employer's unreasonable conduct, the Referee assessed a single penalty for both actions. On review, claimant asserts that either unreasonable action justifies a penalty. We agree with claimant's assertion.

However, we have already assessed a penalty of 25 percent of all amounts then due at the date of hearing, and there is no legal authority for assessing penalties totalling more than 25 percent of the compensation then due. Robert A. Brooks, Jr., 44 Van Natta 1105 (1992); Mollie E. Barrow, 43 Van Natta 617 (1991). On the other hand, the Board can award a separate attorney fee for separate unreasonable conduct that relates to a different factual basis. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Inasmuch as the employer has committed two separate unreasonable acts, we hold that claimant is entitled to a carrier-paid attorney fee award under ORS 656.382(1) for the employer's denial which constitutes an unreasonable resistance to the payment of compensation.

Accordingly, after considering the factors set forth in OAR 438-15-010(4), we award an assessed attorney fee of $700, for the employer's unreasonable resistance to the payment of compensation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 2, 1993 is modified in part and affirmed in part. For the self-insured employer's unreasonable denial, claimant's attorney is awarded an assessed attorney fee of $700, payable by the self-insured employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ROBERTO R. CASTILLO, Claimant
WCB Case No. 93-05479
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Barber's order which upheld the insurer's denial of claimant's injury claim for a lumbar strain and right trapezius strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the finding that claimant did not dump a barrel of waste on January 28, 1993.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not a credible witness, and thus, did not injure himself at work as he had testified. As a matter of policy, we generally give "deference to findings made by the Referee, especially when they relate to witness credibility." Erck v. Brown Oldsmobile, 311 Or 519, 525 (1991). However, we are not statutorily required to explain our departure from a referee's credibility determination. Id. at 526. Instead, pursuant to our de novo review authority, we may "affirm, reverse, modify or supplement the order of the referee and make such disposition of the case as [we determine] to be appropriate." ORS 656.295(6); see ORS 656.295(5); 311 Or at 523. Further, even if we assume claimant was not a credible witness, it does not necessarily follow that he did not prove his claim. See Taylor v. Multnomah School District # 1, 109 Or App 499, 501 (1991); Robert E. Vanwormer, 46 Van Natta 328 (1994). Here, on de novo review, we independently assess claimant's credibility. Erck v. Brown Oldsmobile, supra.

If claimant lacks credibility in certain matters, he can still meet his burden of proof if the remainder of the record supports his version of how he was injured. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985); Brett D. Adair, 46 Van Natta 378, 379 (1994).

Here, there is no question that claimant testified untruthfully in certain instances. Among those were when he claimed he emptied barrels every single day (Tr. 103); when he embellished the extent of his injury (video tape evidence; Tr. 95-102); and when he responded to questions concerning the collateral (and irrelevant) matter of making sexual paraphernalia at work.

Testimony given by the co-workers who worked most closely with claimant establishes that it was not claimant's regular job to empty the trash barrels each day at the end of his shift. Nevertheless, one witness, Ms. McNett, stated that she had seen claimant empty barrels on occasion. (Tr. 38).

Mr. Dickson, supervisor, testified that he had been told by Ms. McNett on the day following claimant's injury that claimant had hurt his back at work. (Tr. 82). Further, contemporary medical evidence supports claimant's account of his injury (Exs. 2, 3), and the record contains no evidence of off-work activities which would account for the strain experienced by claimant. Accordingly, after our de novo review, we are persuaded that claimant suffered a work-related injury on January 28, 1993.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 30, 1993 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed attorney fee of $3,000, payable by the insurer.

In the Matter of the Compensation of
GAIL L. NORRIS, Claimant
WCB Case Nos. 92-13363 & 92-11551
ORDER ON REVIEW (REMANDING)
Coons, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Hall, Westerband, and Haynes.

Claimant requests review of Referee Livesley's order that: (1) denied claimant's motion to leave the record open for the deposition of the treating physician; (2) upheld the self-insured employer's denial of claimant's occupational disease claim for a left shoulder condition; and (3) declined to assess a penalty and attorney fee for the alleged untimely denial. On review, the issues are remand/evidence, compensability, penalties and attorney fees. We remand.

FINDINGS OF FACT

We adopt the findings set forth in the "Findings of Fact" section of the Referee's order, subject to the following corrections and/or supplementation.

Claimant suffered right (not left) radicular arm pain as a result of his October 10, 1991 neck and right shoulder injury. The 1991 MRI evidencing an intact rotator cuff was of the right shoulder, not the left.

Claimant experienced the onset of left shoulder symptoms several weeks after returning to work for the employer in April 1992. The onset of claimant's left shoulder symptoms coincided with increased use of that shoulder to lift and carry a heavy lathe knife.

Claimant served the employer with a Notice of Expert Witness on November 6, 1992. That notice informed the employer that claimant might call the treating physician, Dr. Norris, as an expert witness at the hearing before Referee Daughtry scheduled for November 19, 1992. The hearing was subsequently postponed at the employer's request and rescheduled before Referee Livesley. Claimant did not amend the Notice of Expert Witness to reflect the new hearing date and referee.

In introductory remarks at the hearing, claimant's attorney stated that Dr. Norris would probably be called as a witness. (Tr. 2). The employer did not object to Dr. Norris' appearance. It later became clear that Dr. Norris would not be available because of a medical emergency. Claimant's attorney then requested that the doctor's testimony be taken by deposition. (Tr. 18). At this point, the employer objected to the deposition on the ground that the Notice of Expert Witness was insufficient under OAR 438-07-016. (Tr. 18). The Referee refused to leave the record open for Dr. Norris' deposition.

FINDING OF ULTIMATE FACT

The record has been insufficiently developed without the deposition of Dr. Norris.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that the Referee's refusal to allow Dr. Norris' deposition was an abuse of discretion under OAR 438-07-016. That rule provides as follows:

> "Within the times provided for the initial exchanges of exhibits and indexes under [OAR] 438-07-018, each party shall disclose to all the parties the identity of each expert witness the party will call to testify at the hearing. A statement by a party that the party "reserves the right," or similar language, to call as a witness any expert whose opinion has been included in the documents filed in the case is not compliance with this rule. At the hearing the referee may, in his or her discretion, allow the testimony of expert witnesses not disclosed as required by this rule. In the exercise of this discretion, the referee shall determine whether material prejudice has resulted from the time of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs the prejudice to the other party or parties."

At hearing, the employer opposed Dr. Norris' deposition on the ground that claimant's Notice of Expert Witness was insufficient because: (1) it referenced the postponed hearing date with Referee Daughtry rather than the actual hearing before Referee Livesley; and (2) it did nothing more than reserve the right to call Dr. Norris as an expert witness.

The Referee rejected the first argument but was persuaded that the notice merely reserved claimant's right to call Dr. Norris. The Referee also concluded that the employer would be prejudiced by Dr. Norris' deposition, and that claimant had not shown good cause outweighing the prejudice. Accordingly, the Referee refused to keep the record open for Dr. Norris' deposition.

Like the Referee, we are not persuaded by the employer's argument that claimant's notice of expert was insufficient because it referenced the original hearing date and referee. That information was correct when the notice issued. There is no requirement that a party issue a new or amended notice when a hearing is postponed or reassigned to a different referee. Claimant's notice was never withdrawn and it remained in effect at the time of hearing.

Accordingly, we agree with the Referee's conclusion that the notice was not insufficient merely because it referenced the postponed hearing. However, we disagree with the remainder of the Referee's analysis and conclude that the Referee abused his discretion in this matter.

We recognize that claimant's notice was somewhat vague in that it indicated that claimant might call Dr. Norris. Nevertheless, the employer failed to timely object at the beginning of the hearing when claimant's attorney named Dr. Norris as an expert witness. (Tr. 2-7). Far from objecting, the employer indicated that it intended to rely on Dr. Norris to prove its case. (Tr. 7). Under these circumstances, the employer waived any right to later claim surprise or prejudice from Dr. Norris' deposition. Accordingly, the Referee should have allowed the deposition, and his failure to do so was an abuse of discretion.

We may remand a case to the Referee for further evidence taking, correction or other necessary action when we determine that a case has been improperly, incompletely, or otherwise insufficiently developed. We conclude that remand is an appropriate action in this case.

Finally, we address the employer's alternative argument that it should be allowed to submit further medical reports on remand in response to Dr. Norris' deposition. We disagree. Dr. Norris' deposition will be taken in lieu of his appearance at hearing. The employer would have had no right to submit further medical reports in response to Dr. Norris' testimony at hearing. It, therefore, follows that the employer should not be allowed to submit further evidence on remand merely because Dr. Norris will testify by deposition.

Accordingly, we remand this case to the Referee for Dr. Norris' deposition. The employer may cross-examine Dr. Norris at the deposition, but it may not submit additional medical reports. The Referee shall issue an order on remand indicating the effect, if any, Dr. Norris' deposition has upon his original order.

ORDER

The Referee's order dated May 19, 1993 is vacated. This case is remanded to the Referee for further action consistent with this order.

Board Member Haynes dissenting.

I disagree with the majority's decision to remand this case for the deposition of Dr. Norris. Accordingly, I respectfully dissent.

At hearing, claimant's attorney announced his intention to call Dr. Norris as a witness for the purpose of clarifying any confusion over the correct diagnosis of claimant's condition. (Tr. 6). However, the record contains test results that definitively establish that claimant suffers from a rotator cuff tear. (Ex. 10, 11).

Moreover, the relative persuasiveness of the medical opinions in the record is not dependent on the diagnosis of claimant's condition. As a result, an additional diagnostic opinion would not affect the ultimate outcome of this case. To the extent the majority would allow Dr. Norris to also expound on issues of causation, admission of such evidence is clearly beyond the limited scope of the deposition requested at hearing.

Accordingly, I would deny claimant's motion to remand and address the merits of the employer's denial. Claimant contends that his left shoulder condition is compensable as an occupational disease. Thus, he must prove that his work activity for the employer was the major cause of the onset or worsening of his left shoulder pathology, as distinct from his symptoms. ORS 656.802.

In a well-reasoned and persuasive opinion, Dr. Woolpert opined that claimant's left shoulder pathology is due in major part to a gradual, natural degeneration of the left shoulder. In support of his opinion, Dr. Woolpert noted the absence of any specific work injury to claimant's shoulder that would have caused his pathology. He also noted that claimant exhibited similar degenerative changes in his right shoulder. Finally, Dr. Woolpert explained that claimant's work activity with the employer made the shoulder symptomatic but did not cause or worsen the underlying pathology.

Dr. Woolpert's opinion is entitled to deference because he is an orthopedic surgeon with special expertise in evaluating mechanical shoulder problems. I am aware that he diagnosed claimant's condition as an impingement syndrome rather than a full-blown rotator cuff tear. Nevertheless, Dr. Woolpert's causal analysis is equally applicable to the latter diagnosis.

Furthermore, his analysis is more persuasive than the contrary opinions of the treating doctors. (Ex. 5, 7). In particular, the treating doctors fail to address the relative contribution of the preexisting degenerative changes diagnosed by Dr. Woolpert. Nor do they focus on the underlying shoulder pathology as distinct from claimant's symptoms.

Accordingly, I would defer to Dr. Woolpert and conclude that claimant has not established that her work activity is the major cause of her pathology.

In the Matter of the Compensation of
BONNIE A. STAFFORD, Claimant
WCB Case Nos. 93-09174 & 93-08558
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys
Betsy Byers (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Fire & Casualty Insurance Co. (EBI), on behalf of Temp Source, Inc., requests review of Referee Spangler's order that: (1) set aside its denial of claimant's claim for bilateral carpal tunnel syndrome; (2) upheld the SAIF Corporation's denial, on behalf of Willie Boats, Inc., of the same condition; and (3) assessed a $2,500 fee payable by EBI for setting aside its denial. In her brief, claimant contends that she is entitled to an attorney fee under ORS 656.382(1) for allegedly unreasonable claims processing by EBI. On review, the issues are responsibility and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's work at Temp Source and at Willie Boats was successive, rather than concurrent, employment and, therefore, applied the last injurious exposure rule. The Referee concluded that Willie Boats, the last potentially responsible employer, had met its burden of establishing that claimant's earlier employment at Temp Source was the sole cause of her carpal tunnel, thereby shifting responsibility. We agree that Temp Source is responsible, but for the following reasons.

Application of the last injurious exposure rule is unnecessary where actual causation with respect to a specific identifiable employer is proven. Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984); Bracke v. Baza'r, 293 Or 239, 249-50 (1982); see also Eva R. Billings, 45 Van Natta 2142 (1993). The evidence shows that claimant's work exposure at Temp Source was the actual cause of her carpal tunnel syndrome.

The only medical evidence regarding causation is from Dr. Grant. Dr. Grant rendered a number of opinions stating that: (1) claimant's work at SAIF's insured did not cause or significantly contribute to her carpal tunnel syndrome; and (2) claimant's carpal tunnel syndrome was definitely unrelated and not in any way related to her work at SAIF's insured. (Exs. 14, 15, 16).[1] Dr. Grant relied on EMG findings which indicated carpal tunnel syndrome of longer than two months duration. (Exs. 6-3, 14). He further explained that the type of work that claimant performed for Temp Source, as a dryer feeder, for over three years was consistent with her carpal tunnel syndrome findings. (Exs. 14, 15). In contrast, claimant's work at SAIF's insured required no firm gripping, was not repetitive or strenuous, and allowed for frequent changes in positions and job tasks. (Ex. 6-2; Tr. 9, 16). At the time claimant sought treatment for her carpal tunnel syndrome, she had been employed by SAIF's insured for about two months.

Although Dr. Grant did not use the words "the major contributing cause" to quantify causation, the doctor did state that claimant's work at Temp Source was the cause of her condition. Because "magic words" are not required to establish compensability, we find his opinion and medical explanations sufficient to meet claimant's burden of proof. See McClendon v. Nabisco Brands, 77 Or App 412 (1986).

Because claimant has established actual causation as to EBI's insured and because claimant's work at Willie Boats did not contribute to the cause of, aggravate, or exacerbate her carpal tunnel syndrome, EBI may not invoke the last injurious exposure rule to shift responsibility from it to SAIF. Bracke v. Baza'r, supra at 250 n. 5 (where claimant does not rely upon the rule of proof, the responsible employer cannot use the rule of proof to defeat the claim); Runft v. SAIF, supra at 501-502 (the employer may use the rule of assignment of responsibility defensively where the evidence establishes that subsequent employment significantly contributed to claimant's disease). Therefore, responsibility lies with EBI.

Attorney Fee at Hearing

The Referee found that the parties did not concede compensability of claimant's bilateral carpal tunnel syndrome until the hearing. Therefore, since claimant's compensation remained at risk until that time, the Referee assessed a $2,500 attorney fee, payable by EBI, for claimant's attorney's services in obtaining rescission of its compensability denial without a hearing.

EBI's April 26, 1993 disclaimer stated that it believed that Willie Boats was responsible for claimant's carpal tunnel syndrome and suggested that claimant file a claim with SAIF. The disclaimer further stated that "without waiving issues of compensability," EBI denied responsibility for claimant's condition. (Ex. 9). On October 13, 1993, EBI issued a denial of responsibility for claimant's carpal tunnel syndrome. This denial included a "notice of hearing" provision. (Ex. 20). We find that the disclaimer in conjunction with the denial created an issue concerning the compensability of the carpal tunnel syndrome claim. Johnny M. Davis, 45 Van Natta 2282 n. 2 (1993). Claimant's compensation was at risk until compensability was conceded at hearing.

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[1] We agree with and adopt the Referee's analysis that Exhibit 19 is of any probative value. Exhibit 19 is Dr. Grant's "check-the-box" response to a hypothetical. However, the hypothetical is based on inaccurate information.

On July 16, 1993, SAIF issued a "disclaimer of responsibility and claim denial." Although the letter stated that SAIF had requested a "307" order, the letter stated that SAIF denied claimant's claim on the ground that her employment at Willie Boats Inc. was not the major contributing cause of her carpal tunnel syndrome. SAIF's letter also included a "notice of hearing" provision consistent with a denial of compensation. No "307" order issued formally acknowledging SAIF's concession of compensability. Given the above, we find that SAIF's July 16, 1993 disclaimer and denial also raised an issue concerning compensability of the claim and similarly kept claimant's compensation at risk.

Accordingly, we conclude that claimant is entitled to an assessed fee for her counsel's efforts in obtaining a pre-hearing concession of compensability. Penny L. Hamrick, 45 Van Natta 14 (1994). Because both insurers created the need for claimant to establish the compensability of her claim, and because claimant's counsel has been instrumental in securing the rescission of both insurers' compensability denials, claimant's counsel is entitled to a separate attorney fee for each rescission. John W. Wantowski, 46 Van Natta 1158 (1994); Dale A. Karstetter, 46 Van Natta 147 (1994); see James F. Herron, 45 Van Natta 842 (1993).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $750 is a reasonable assessed attorney fee for claimant's counsel's services concerning the rescission of the compensability portion of the denial issued by SAIF. However, inasmuch as the Referee has already awarded claimant's counsel a $2,500 assessed fee for his services in setting aside EBI's denial, we conclude that this is a reasonable fee for counsel's pre-hearing and hearing services concerning EBI's denial. Therefore, in addition to the Referee's attorney fee award, claimant's attorney is awarded a separate $750 attorney fee, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, (as represented by the hearing record), the complexity of the issues presented, the risk that claimant's counsel might go uncompensated, and the value of the interest to claimant.

Attorney Fee at Board Level

Claimant's counsel has requested an assessed attorney fee under ORS 656.382(1) contending that EBI unreasonably denied compensability of and responsibility for her condition, thereby unreasonably resisting the payment of compensation.

We need not decide this issue because we find that claimant failed to raise this issue at hearing. Consequently, we decline to consider it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

Claimant is also not entitled to a fee under ORS 656.382(2). ORS 656.382(2) authorizes attorney fees when claimant's right to compensation is at risk of disallowance or reduction. Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). Claimant's 801 forms indicate that her hourly rate for Temp Source was $7.25 per hour and that she worked eight hours a week. Claimant earned $7 per hour at Willie Boats, but worked 40 hours a week. Thus, claimant's compensation was not at risk of reduction as a result of EBI's appeal since her temporary disability rate under the EBI claim was less than under the SAIF's claim. Under such circumstances, claimant is not entitled to an assessed fee under ORS 656.382(2).

ORDER

The Referee's order dated November 8, 1993, as reconsidered December 7, 1993, is modified in part and affirmed in part. For claimant's counsel's efforts in obtaining withdrawal of the compensability portion of SAIF's denial without a hearing, claimant's attorney is awarded a $750 attorney fee, payable SAIF. The remainder of the order is affirmed.
Bischoff & Strooband, Claimant Attorneys

In the Matter of the Compensation of
LORNA I. YOUNG, Claimant
WCB Case Nos. 93-06731 & 93-05977
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Mitchell, et al., Defense Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of those portions of Referee Menashe's order which: (1) set aside its denials of claimant's "new injury" claim for a low back condition; and (2) upheld USF&G's denial of claimant's aggravation claim for the same condition. In her brief, claimant contends that SAIF issued a "back-up" denial. On review, the issues are "back-up" denial, remand and responsibility. We deny the motion for remand and reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

"Back-Up" Denial

SAIF initially denied both compensability and responsibility. In a subsequent conference call prior to hearing, SAIF conceded compensability. Afterward, but still prior to hearing, SAIF retracted its concession of compensability and indicated it was contesting compensability as well as responsibility. Claimant contends that SAIF's retraction of its concession of compensability constitutes a "back-up" denial, requiring it to prove by "clear and convincing evidence" that claimant's injury was not compensable and that SAIF is not responsible. See ORS 656.262(6).

We disagree with claimant's contentions. A concession in a responsibility context that a claim is compensable does not constitute an acceptance of the claim. See Taylor v. Masonry Builders, Inc., 127 Or App 230 (1994); Allen v. Bohemia, Inc., 125 Or App 205, 208 (1993). Accordingly, since the record does not establish that SAIF ever accepted claimant's claim, we do not find that SAIF's subsequent retraction constituted a "back-up" denial.

Responsibility

The Referee found that a "new injury" had occurred during claimant's employment for SAIF's insured, applying a "material contributing cause" standard. However, subsequent to the Referee's order, the Supreme Court held that the major contributing cause standard of ORS 656.005(7)(a)(B) applies to the shifting of responsibility among employers under ORS 656.308. SAIF v. Drews, 318 Or 1 (1993).

Both Dr. Brett, claimant's attending physician, and Dr. Fuller, an examining physician, agree that claimant's original injury in 1991, for which USF&G is responsible, is the major contributing cause of claimant's current need for treatment. (Exs. 34A, 36). There are no other medical opinions addressing the causation issue. Thus, the record does not establish that claimant suffered a "new compensable injury" while working for SAIF's insured. See ORS 656.308; SAIF v. Drews, supra. Rather, we find that the uncontroverted medical evidence establishes that USF&G is responsible for claimant's current low back condition. Accordingly, we reverse the Referee's decision setting aside SAIF's denials.

Although the record establishes that responsibility for the claim rests with USF&G, we note that claimant has settled her claim with USF&G on the basis of a disputed claim settlement. Specifically, on April 8, 1994, we issued an interim order acknowledging our approval of that agreement. In so doing, we noted that, in settling her claim against USF&G, claimant accepted the risk that she would not receive compensation from the remaining carrier (SAIF). See E.C.D., Inc. v. Snider, 105 Or App 416 (1991); Bren R. Athens, 44 Van Natta 2469, 2471 (1992). For the reasons expressed above, that risk has become a reality. Inasmuch as we have approved a settlement that upholds USF&G's denial, claimant is not entitled to compensation for her low back condition under the USF&G claim.

ORDER

The Referee's order dated September 15, 1993 is reversed. SAIF's denials are reinstated and upheld. The Referee's attorney fee award is reversed. The Board's April 8, 1994 Interim Order of Dismissal is hereby incorporated into this order.

In the Matter of the Compensation of
DOUGLAS A. ANDERSON, Claimant
WCB Case No. 91-07281
ORDER WITHDRAWING DISMISSAL ORDER
Doblie & Associates, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

On June 17, 1994, we withdrew our May 18, 1994 order which had dismissed the SAIF Corporation's request for Board review. In dismissing the employer's appeal, we had presumed that SAIF's request (which was not mailed by certified mail and was actually received by the Board more than 30 days from the Referee's October 7, 1991 order) was untimely. See OAR 438-05-046(1)(b). However, noting that this presumption was rebuttable, we advised the employer that we were willing to reconsider our decision provided that SAIF could establish that its request for review was timely mailed to the Board.

On June 17, 1994, we withdrew our dismissal order to consider affidavits from SAIF's legal counsel and counsel's legal secretary which attest that it is SAIF's usual and customary procedure to mail requests for review on the date the request is prepared and dated. We also granted claimant an opportunity to respond. Having received claimant's response, we proceed with our reconsideration.

According to affidavits from SAIF's counsel and counsel's legal secretary, it is SAIF's usual and customary practice to mail requests for Board review on the same day they are prepared and dated. SAIF has also submitted a copy of its request for Board review (dated October 15, 1991) and a copy of a certificate of mailing attached to the request. The certificate of mailing contains SAIF's counsel's certification that a request for review was mailed to the Board on October 15, 1991, as well as to claimant's attorney, Liberty Northwest's attorney, Liberty Northwest, and SAIF's insured. With the exception of its insured, SAIF has also included copies of requests for Board review containing date stamps which indicate that these copies were received by the other parties and their respective counsels between October 16, 1991 and October 21, 1991.

In response, claimant asserts that SAIF's affidavits regarding its usual and customary practice for mailing requests for Board review does not establish that SAIF actually mailed a request for review in this case to the Board. Likewise, claimant contends that the parties' or their attorneys' receipt of a copy of the request does not prove that SAIF mailed a request for review to the Board. Finally, in the absence of a date stamp from the Post Office or a certified mail receipt, claimant argues that SAIF's counsel's certificate of mailing is insufficient to rebut the presumption that SAIF's request for review was untimely mailed to the Board.

Standing alone, each of these contested representations would likely be insufficient to overcome the "untimely filing" presumption of OAR 438-05-046(1)(b). However, when all of these circumstances are considered, they establish that it is more probable than not that SAIF mailed its request for review of the Referee's October 7, 1991 order to the Board on October 15, 1991. Inasmuch as October 15, 1991 is within 30 days of the Referee's order, we hold that SAIF has rebutted the presumption that its request for Board review was untimely filed.

In reaching this conclusion, we are particularly persuaded by SAIF's counsel's certificate of mailing which accompanied its copy of the October 15, 1991 request for Board review. Pursuant to that certificate, SAIF's counsel represents that SAIF mailed its request for review to the Board on October 15, 1991. That certificate also states that copies of the request were likewise mailed to claimant's attorney, Liberty Northwest's attorney, Liberty Northwest, and SAIF's insured. Receipt of three of these four notices within a few days of their mailing has also been confirmed. (Receipt of the fourth notice has not been contested; rather, SAIF has been unsuccessful in contacting its insured.)

In conclusion, based on SAIF's certificate of mailing, as supported by the other parties' and their representatives' timely receipt of their respective copies of the requests for review, we find that SAIF mailed its request for review to the Board within 30 days of the Referee's order. Consequently, we hold that we have authority to consider SAIF's appeal.

Accordingly, on reconsideration, we withdraw our May 18, 1994 dismissal order. A hearing transcript has been ordered. On its receipt, copies will be distributed to the parties along with a briefing schedule.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATSY B. HOUSE, Claimant
WCB Case No. 93-10678
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Howell's order that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral trigger thumb. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

Claimant is ambidextrous.

On July 29, 1993, the day on which claimant's right thumb first locked, she was at home, and had done only light housework. She has no hobbies involving intensive or repetitive use of the right thumb.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, based on the report of examining physician Dr. Jewell, claimant failed to prove the compensability of her trigger thumb condition. We disagree.

We briefly recount the facts. Claimant was employed as a laundry worker for the employer. Her job duties included lifting heavy loads of laundry out of barrels and wringing out any wet laundry with both hands before placing it in washing machines.

Claimant began working for the employer in March 1993. Her thumbs began hurting on July 24, 1993. On July 29, while she was at home, her right thumb locked. On that day, claimant had only done light housework. She sought emergency room treatment for both thumbs, and was referred to Dr. Frazer, family practitioner. Dr. Frazer treated claimant conservatively with little success. He referred claimant to Dr. Butler, orthopedic surgeon, who eventually performed a surgical release of both thumbs.

The sole issue presented by this case is whether claimant has established that her work activities were the major contributing cause of her trigger thumb condition. See ORS 656.802(2). Four physicians have rendered opinions regarding the cause of claimant's condition.

Dr. Butler, claimant's treating surgeon, initially concluded that, based on claimant's history and work activities, claimant's condition was work-related. (Ex. 15-3). He adhered to that opinion even after he realized that claimant's thumb first locked up while she was at home. (See id. at 4; see also Exs. 21, 23).

Dr. Fuller examined claimant on the employer's behalf. He determined that claimant had developmental nodules in all of the flexor tendons of both hands. He concluded that, because the nodules were not work-induced, claimant's work should not be regarded as the cause of claimant's trigger thumb condition. (Ex. 17-3, -4). Instead, Fuller concluded that claimant's trigger thumb condition was idiopathic and that "the hand use in her work made a contribution similar to the hand use

of activities of daily living." (Id. at 4). For that reason, Fuller opined that claimant's work was not the major contributing cause of her trigger thumb condition. (Id.).

Dr. Butler disagreed with Dr. Fuller's conclusions. Referring to Bunnell's Surgery of the Hand, a medical text that discussed the etiology of trigger finger,[1] Dr. Butler stated:

> "It mentions that the nodule of the flexor tendons, catching at the constriction of the annular sheath opposite the metacarpal head is usually caused by single or multiple direct trauma, usually incurred in grasping and is common in diabetics and people with rheumatoid disease. The ligamentous sheath and the flexor tendon are pinched between the object being grasped and the head of the metacarpal until a local tenosynovitis and thickening forms, which then produces the nodule which leads to the triggering. In other words, according to this authoritative book on hand surgery, the development of triggering phenomena of the flexor tendons at the A-1 pulley is not 'idiopathic,' but appears to be related to direct trauma." (Ex. 21-2; see Ex. 8A-3 (excerpt from text to which Dr. Butler referred)).

Because Dr. Butler believed that the degree of grasping that claimant was required to do at work far exceeded that required of most people, he concluded that claimant's work activities were the major contributing cause of her triggering phenomena. (Id.)

Dr. Jewell, plastic and hand surgeon, also examined claimant on the employer's behalf. He concluded that, because claimant did not use hand implements, screw drivers or scissors at work, and because she did not have a history of hand trauma,[2] he was unable to state with a reasonable medical probability that her work activities were the major contributing cause of her trigger thumb condition. (Ex. 22-3). Jewell also concluded that, because reported cases of trigger fingers usually involved the right hand, thereby suggesting a traumatic etiology, a bilateral trigger finger condition would not have a traumatic origin. (See id.) Instead, Jewell concluded that claimant appeared to have congenital flexor tendon nodules that predisposed her to trigger thumb phenomena regardless of her work and off-work activities. (Id.)

Thereafter, Dr. Butler issued a final opinion in which he continued to adhere to his conclusion that, based on his determination that claimant's work activities required excessive grasping with her hands and thumbs, her work activities were the major contributing cause of her trigger thumb condition. (Ex. 23).

We give the most weight to medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). For the following reasons, we conclude that Dr. Butler's opinions are entitled to the most weight and are sufficient to establish the compensability of claimant's trigger thumb condition.

Dr. Butler considered the traumatic nature of claimant's work -- repetitively lifting and wringing out laundry, an activity that required much more grasping with the thumb than that required of the general population. Dr. Butler then concluded that, in light of the mechanism of injury described in Bunnell's Surgery of the Hand, claimant's repetitive work trauma, not any idiopathic factor, was the major cause of her trigger thumb condition. We understand Dr. Butler to mean that claimant's work trauma caused the flexor tendon nodules, which in turn caused claimant's triggering phenomena. (See Ex. 21-2). We find that reasoning both straightforward and persuasive. Furthermore, in view of the fact that there is no evidence that claimant engaged in any off-work activities which involved intensive use of the thumb, we conclude that Dr. Butler's opinions establish compensability of claimant's trigger thumb condition.

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[1] The language to which Dr. Butler referred concerns trigger finger, not trigger thumb. (See Ex. 8A-3). We find no medical evidence questioning his reference to trigger finger phenomena in analyzing the cause of claimant's trigger thumb condition.

[2] Claimant has a history of a trigger finger condition of the right ring finger, but no history of thumb trauma.

In contrast, we find compelling reasons to discount the opinions of Drs. Fuller and Jewell. Both doctors concluded that, by virtue of the fact that claimant had developmental flexor tendon nodules, she was predisposed to developing trigger thumb phenomena.[3] In light of Dr. Butler's well-reasoned reports, we are not persuaded that claimant's nodules were developmental. However, even if we were, we would discount Drs. Fuller's and Jewell's reports. Neither physician determined that claimant's nodules were a cause of her trigger thumb condition; rather, they merely stated that the nodules predisposed claimant to develop trigger thumb. Because a mere predisposition to developing a condition is not relevant to compensability, Dianna E. Sturgis, 46 Van Natta 8 (1994), see Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992), those portions of the doctors' opinions are entitled to no weight.

We find an additional reason to discount Dr. Fuller's opinion. He reasoned that, because claimant was predisposed to develop a trigger thumb condition, that condition was necessarily not work-related. We reject that reasoning, because it fails to recognize that a carrier is responsible for a disease that a claimant who has a particular susceptibility or predisposition develops due in major part to work conditions. Liberty Northwest Ins. Corp. v. Spurgeon, supra, 109 Or App at 569.

We also find another basis to discount Dr. Jewell's opinion. He concluded that, because claimant did not use hand implements, screw drivers or scissors at work, and because there is a higher incidence of right-sided trigger finger condition, claimant's condition must have been caused by idiopathic factors. We find that reasoning without logical basis, because it fails to account for the fact that claimant's work required that she repetitively grasp and wring out laundry. Furthermore, claimant's bilateral hand symptoms may be explained by the facts that she was ambidextrous and that she was required to use both hands to process the laundry. In light of this evidence, we find Dr. Jewell's opinion worthy of no probative weight.

The employer argues that Dr. Frazer's report is entitled to no weight because it is poorly reasoned and because Frazer is not a hand specialist. Because we have concluded that Dr. Butler's reports are sufficient evidence of the compensability of claimant's trigger thumb condition, we need not address that argument. Accordingly, based on Dr. Butler's well-reasoned opinion, we conclude that claimant has established compensability of her trigger thumb condition as an occupational disease.

Claimant is entitled to an assessed attorney fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's and reply briefs and the hearing record), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated December 17, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded $3,500, to be paid by the self-insured employer.

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[3] In his initial report, Dr. Butler suggested that claimant may have been predisposed to developing a trigger thumb condition. (Ex. 15-3). However, he also made it clear that it was claimant's work activities that brought about the actual condition. (Id.)

In the Matter of the Compensation of
MONTE W. KENTTA, Claimant
WCB Case No. 93-08499
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Hazelett's order that: (1) declined to order the SAIF Corporation to pay temporary partial disability awarded by a Notice of Closure at a higher rate; and (2) declined to award penalties. In its brief, SAIF contends that the Referee lacked jurisdiction to address claimant's entitlement to temporary disability benefits awarded by two Notices of Closure. On review, the issues are jurisdiction, temporary disability and penalties. We vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact; however, we do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

At the hearing, claimant contended that he was seeking to enforce Notices of Closure dated January 6, 1993 and January 27, 1993. These Notices of Closure awarded claimant compensation for temporary partial disability for the period including January 31, through May 13, 1992. Specifically, claimant contended that his employer had withdrawn an offer of modified employment on January 31, 1992, and that, as a consequence, he was entitled to have temporary partial disability paid at the "full rate" from January 31, 1992 to May 13, 1992. SAIF had paid temporary partial disability benefits from January 31, through May 13, 1992 at the same rate it would have paid if claimant had continued to work full time at his modified job.

Reasoning that claimant sought to enforce and not to modify the January 6, 1993 and January 27, 1993 Notices of Closure, the Referee found that the Hearings Division had jurisdiction over this matter. Notwithstanding his conclusion that he had jurisdiction to enforce the Notices of Closure, the Referee found that the employer had not withdrawn the offer of modified work and that, therefore, claimant had not established entitlement to a higher rate of temporary partial disability.

Claimant, who was compensably injured in December 1991, began performing modified work for the employer in January 1992. Claimant's contention on review is that his employer withdrew its modified job offer. On this basis, claimant argues that he was entitled to the "full rate" of temporary partial disability from January 31, 1992 through May 13, 1992 since he had no earnings during that period. Claimant further contends that since the offer of modified employment was withdrawn, SAIF failed to comply with the Notice of Closure awards because it incorrectly calculated claimant's temporary partial disability benefits as if claimant had continued to work at his modified job. Claimant argues that he does not seek any modification of the award of temporary partial disability and characterizes the issue as "enforcement" of the Notice of Closure.

SAIF, on the other hand, contends that claimant's argument raises his substantive entitlement to temporary total disability. On this basis, SAIF argues that the Referee did not have jurisdiction to address claimant's entitlement to temporary disability because claimant first had to request reconsideration of the Notice of Closure by the Department before requesting a hearing on this issue. For the following reasons, we agree with SAIF that we lack jurisdiction over this matter, and we vacate the Referee's order.

OAR 436-60-030(11) provides that temporary partial disability compensation shall continue until the modified job no longer exists or the job offer is withdrawn by the employer. The rule further provides that the worker is entitled to temporary total disability compensation as of the date the job is no longer available.

We have held that temporary total disability must be reinstated when an offer of modified employment is withdrawn. See Arturo G. Vasquez, 44 Van Natta 2443 (1992); Shirley J. Sanderson, 44 Van Natta 484 (1992); Kati A. Hanks, 44 Van Natta 881 (1992). If claimant establishes that the employer withdrew its modified work offer, he would be entitled to reinstatement of temporary total disability, not temporary partial disability. OAR 436-60-030(11). Under ORS 656.268(4)(e) and (5), the Hearings Division lacks initial jurisdiction to address challenges regarding an injured worker's substantive entitlement to temporary disability. See Kenneth W. Metzker, 45 Van Natta 1631, 1632 (1993). Although he characterizes the issue as an "enforcement" of the Notices of Closure and contends that he is seeking the "maximum rate" of temporary partial disability, what claimant is really seeking is temporary total disability.

Regardless of how he characterizes this dispute, claimant is seeking temporary total disability benefits from January 31, 1992 until May 13, 1992 instead of the temporary partial disability benefits awarded by the Notices of Closure. In other words, claimant seeks a substantive change to the Notice of Closure without first requesting reconsideration of that order.

We find this case factually similar to Mindi M. Miller, 44 Van Natta 2144 (1992) (on reconsideration). There, the claimant had returned to modified work at her regular wage, but was subsequently taken off work by her physician. A Determination Order had awarded only temporary partial disability. Claimant requested a hearing on the Determination Order seeking to have the award enforced. The referee addressed the merits of the temporary disability issue and found that the claimant was not able to work after September 4, 1990. Based on this finding, the referee awarded temporary total disability after September 4, 1990.

On Board review in Miller, the claimant argued that she should receive temporary partial disability at the "full rate." We concluded that claimant was, in effect, arguing that since her doctor released her from work on September 5, 1990, she was entitled to temporary total disability after this date. In reversing the referee's order, we held that, because the claimant did not request reconsideration of the Determination Order, the referee was without authority to determine the claimant's substantive entitlement to temporary total disability for a period during which the Determination Order awarded temporary partial disability.

In the present case, as in Miller, claimant seeks to establish that he is substantively entitled to temporary total disability during a period for which the Notice of Closure awarded only temporary partial disability. Thus, because claimant seeks modification of the Notice of Closure to award temporary total disability from January 31, 1992 to May 13, 1992, we lack jurisdiction. To challenge the Notice of Closure's award on substantive grounds, claimant must first request reconsideration from the Department prior to requesting a hearing. ORS 656.268(4)(e); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

Claimant also asserts entitlement to penalties for SAIF's allegedly unreasonable claims processing. Because we have found that we lack jurisdiction to alter the Notice of Closure award of temporary disability, the only remaining issue before us is penalties. Where the sole issue is entitlement to penalties under ORS 656.262(10)(a), the Director has exclusive jurisdiction. Corona v. Pacific Resource Recycling, 125 Or App 47 (1993).

ORDER

The Referee's order dated October 25, 1993 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction.

In the Matter of the Compensation of
ANNE M. MALEY, Claimant
WCB Case Nos. 91-09137, 91-03931, 90-06629 & 91-02379
ORDER ON REMAND
Burt, Swanson, et al., Claimant Attorneys
Holmes, Hurley, et al., Attorneys
David R. Fowler (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys
Cummins, Brown, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Timm v. Maley, 125 Or App 396 (1993). The court has reversed our prior order that found the SAIF Corporation (as claim processor for the noncomplying employer) responsible under pre-June 20, 1990 law for claimant's occupational disease claim for a low back condition. Reasoning that we misapplied the "last injurious exposure rule," the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant had received treatment for her back problems before her employment with Steven Timm, DMD. Timm was insured by CNA from October 1, 1986 through March 17, 1988. Timm was a noncomplying employer from March 18, 1988 until September 22, 1988. Beginning September 23, 1988, SAIF provided insurance coverage for Timm.

Relying on Bracke v. Baza'r, 293 Or 239 (1982), the Referee found that claimant became disabled in May 1988 when she first missed work due to her low back condition. Since no party was contending that claimant's "post-September 1988" claim exposure contributed to her condition, the Referee concluded that SAIF, as the statutory claim processor for the noncomplying employer Timm, was responsible for claimant's occupational disease.

In applying the "last injurious exposure rule," we reasoned that the date claimant first left work was dispositive for the purpose of assigning responsibility. The court has reversed, concluding that if a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App at 401. Since we had not expressly decided when claimant's treatment became compensable or whether claimant's subsequent employment contributed independently to the cause of her condition, the court has remanded for reconsideration. Id. In accordance with the court's instruction, we proceed with our reconsideration.

Claimant began working for Timm as a dental assistant in October 1983. The Referee found, and we agree, that claimant first developed significant left leg and foot pain and numbness in late July 1987.

Dr. Lang, a chiropractor, had treated claimant on various occasions since 1980. Dr. Lang reported that claimant returned to his office in July 1987 complaining of left sacroiliac pain. (Ex. 16). Claimant had commented during her treatment in mid-year 1987 that "her occupation working as an assistant in a dental office caused irritation to her low back and specifically aggravated either her right or left sacroiliac joints on a fairly frequent basis." (Id.) Dr. Lang said that he "attempted treating her a few times with little improvement and referred her to Dr. Kendrick, a [n]eurosurgeon, because of the persistentness of her low back pain as well as the unprecedented intensity of pain down her left leg." (Id.) Claimant was examined by Drs. Kendrick and Altrocchi and was referred to Dr. Mann, an osteopathic physician, for treatment.

We conclude that the date that claimant first began to receive medical treatment related to her compensable condition was late July 1987, when CNA insured Timm.[1] Therefore, CNA is initially assigned responsibility for claimant's low back condition.

In order to shift responsibility to a later carrier, the initially responsible carrier must show that a later employment actually contributed to a worsening of the condition. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Spurlock v. International Paper Co., 89 Or App 461, 465 (1988).

Considering claimant's extensive history of low back complaints and the varying periods of employment exposures for different carriers, we consider the causation issue to be a complex question. Therefore, we rely on expert medical opinion to resolve the issue. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). We rely on those opinions that are well-reasoned and based on an accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986). Absent persuasive reasons to the contrary, we give greater weight to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983).

Claimant's attending physician, Dr. Mann, reported in August 1989 that claimant had "an on the job exacerbation of back pain on about May 1st 1988." (Ex. 20). Dr. Mann explained that claimant's course changed dramatically in early May 1988 and her pain behavior was quite dramatic until her last visit on July 12, 1988. Claimant subsequently told Dr. Mann that discontinuation of dental assistant work was the key change that allowed her to return to normal activity without pain.

Dr. Mann concluded that claimant's "job as a dental assistant and the positioning she was in for many years had a definite impact on the previous underlying problem and that her medical needs and requirements for care would not have existed without this repeated stress." (Ex. 20). In a subsequent "check-the-box" letter, Dr. Mann agreed that claimant's work exposure as a dental technician was the major contributing cause of her preexisting underlying condition. (Ex. 24).

Dr. Rosenbaum, a neurologist, reported that there was "no evidence that her work in Dr. Timm's office materially worsened or hastened her condition." (Ex. 12BC). Assuming that claimant's condition was related to work done for Dr. Timm, Dr. Rosenbaum stated that he was unable to separate out the relative contributions of work activities prior to and after March 1988. (Id.)

We do not find Dr. Rosenbaum's opinion persuasive. Dr. Rosenbaum examined claimant on one occasion. In contrast, Dr. Mann treated claimant from September 1987 to July 1988 and had an opportunity to monitor her condition and correlate changes in her condition with her activities. See Weiland v. SAIF, supra.

Our review of the medical evidence establishes that claimant's work activities with Timm during the time he was a noncomplying employer independently contributed to the worsening of her low back condition. Claimant's condition worsened in May, June and July 1988. Consequently, responsibility for claimant's low back condition shifts from CNA to SAIF, as the statutory claim processor under ORS 656.054 for Timm, a noncomplying employer.

No party contends that responsibility for claimant's occupational disease shifted to another carrier after September 1988 (while Timm was insured by SAIF). Claimant returned to work for Timm as a receptionist on August 10, 1988. The receptionist work allowed claimant to sit or stand as necessary and did not require her to twist at the waist. She continued chiropractic treatment for only a short period after returning to work and her condition gradually improved over the next eight or nine months. Under these circumstances, it may well be that responsibility for claimant's occupational disease should not have shifted to another carrier. We note, however, that the record contains little evidence that SAIF, as the statutory claim processor for the noncomplying employer Timm, attempted to shift responsibility to Timm as insured by SAIF, to CNA or even to another carrier before CNA was on the risk.

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[1] We note that the first indication that claimant's back condition was work-related was in mid-February 1985. (Exs. CC & 16). Claimant's chiropractor noted that working as a dental assistant with the left rotation of her low back caused irritation to her low back and aggravated her sacroiliac joints on a fairly frequent basis. (Exs. CC & 16).

Although Timm began practicing as a dentist in 1983, there is no indication what entity or entities insured him for workers' compensation between 1983 and October 1, 1986, when CNA began insuring him. We need not address that issue because it is clear that claimant's subsequent work activities while CNA was on the risk and while Timm was a noncomplying employer contributed to a worsening of her back condition. Thus, responsibility for claimant's condition would shift to the subsequent carriers.

Accordingly, on reconsideration, the Referee's order dated December 9, 1991, is affirmed. Further, we republish that portion of our November 13, 1992 order that awarded claimant's counsel a $500 attorney fee, payable by the SAIF Corporation on behalf of the noncomplying employer.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILL D. NAPIER, Claimant
WCB Case No. 91-17835
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Lipton's order that upheld the self-insured employer's denial of his occupational disease claim for a stress-related mental disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not established a compensable occupational disease claim for a mental disorder. We agree.

In order to establish compensability of a stress-related mental disorder, the worker must prove that employment conditions were the major contributing cause of the mental disorder. ORS 656.802(2). In addition, the employment conditions producing the mental disorder must exist in a real and objective sense. ORS 656.802(3). They must be conditions other than those generally inherent in every working situation, or reasonable disciplinary, corrective or job performance actions by the employer, or cessation of employment. ORS 656.802(3)(b). The claimant has the burden to prove by clear and convincing evidence that work-related stressors, not otherwise excluded by ORS 656.802(3), are the major contributing cause of his mental disorder. See Thrash v. City of Sweet Home, 111 Or App 27 (1992).

Claimant initially filed his stress claim in November 1991. Claimant had received a three day suspension in March 1991 and felt that he was treated differently and more harshly than other workers who had engaged in similar misconduct. Claimant sought treatment from Dr. Smith. Dr. Smith diagnosed claimant's condition as generalized anxiety disorder. The claim was denied on November 25, 1991 and claimant appealed that denial. Subsequently, in March 1992, claimant was suspended and then fired for allegedly disruptive behavior at a company meeting. As a result of the March 1992 events, claimant sought treatment from Dr. Duncan, a psychiatrist, who diagnosed major depression with agitation. Although claimant's original claim which was filed in November 1991 pertained only to stressful events which had occurred prior to that time, at the hearing, claimant's claim for the March 1992 medical treatment was also litigated.

There are three medical opinions in the record concerning the existence and causation of claimant's mental disorder. Drs. Turco and Smith examined claimant before the March 1992 events which led to claimant's termination occurred. Consequently, these physicians address only the events which occurred prior to the filing of the claim in November 1991. Dr. Turco opined that claimant does not have a diagnosable mental condition. Although Dr. Smith diagnosed claimant's condition as "generalized anxiety disorder," he does not give an opinion concerning causation, but indicates that claimant related his condition exclusively to work.

Dr. Duncan treated claimant in March 1992 for "acute depressive process with a large component of anxiety." Dr. Duncan, after seeing claimant one time, opined that claimant's condition was directly related to stress on the job and the perception of injustice, unfairness and prejudice which claimant had related to Dr. Duncan.

We do not find Dr. Duncan's opinion persuasive for the following reasons. Dr. Duncan was unaware of the events which led claimant to file the November 1991 claim, and he had not reviewed the medical opinions of Drs. Turco and Smith. In addition, Dr. Duncan did not know when all of the stressful events claimant described occurred, but assumed they had occurred within a few weeks prior to seeking treatment from Dr. Duncan. Finally, Dr. Duncan was unaware of claimant's prior discipline (the suspension in March 1991). Based on his deposition testimony, we are not convinced that Dr. Duncan had an accurate or complete history of the work events which led up to claimant's claim. Because we find that Dr. Duncan had an inaccurate history, we find his opinion unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

Because we find Dr. Duncan's opinion unpersuasive, we conclude that claimant has failed to prove that his employment conditions were the major contributing cause of his mental disorder. Accordingly, claimant has failed to establish a compensable occupational disease claim. ORS 656.802(2).

ORDER

The Referee's order dated July 9, 1993 is affirmed.

July 14, 1994 Cite as 46 Van Natta 1465 (1994)

In the Matter of the Compensation of
JESUS P. RODRIGUEZ, Claimant
WCB Case No. 93-09794
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee McCullough's order that awarded claimant 20 percent (64 degrees) unscheduled permanent disability for a right shoulder injury. On review, the issue is extent of permanent disability.

We adopt and affirm the Referee's order, with the following comment.

Claimant has an accepted claim for a right shoulder strain. A March 1993 Notice of Closure awarded no permanent disability. An August 1993 Order on Reconsideration awarded 15 percent unscheduled permanent disability. The Referee awarded claimant an additional 5 percent unscheduled permanent.

On review, claimant only contests the adaptability factor. Based on a preponderance of the evidence, i.e., treating physician Zirschky's various reports from February through July 1993, the Referee found that claimant's permanent strength restrictions combined with "other" restrictions (bending, twisting, and reaching), place claimant in the light residual functional capacity (RFC) category. Applying the rating standards in temporary WCD Admin. Order 93-052 and WCD Admin. Order 6-1992, the Referee determined that claimant is entitled to an adaptability value of 3.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules provided in WCD Admin. Order 93-056. However, inasmuch as claimant's claim was closed in March 1993, and WCD Admin. Order 93-056 applies only to those claims closed after December 14, 1993, those rules are not applicable to this case. See OAR 436-30-003(1).
Rather, those standards in effect at the time of the Notice of Closure apply in determining the extent of permanent disability. See OAR 436-30-003(2); Michelle Cadigan, 46 Van Natta 307 (1994). Therefore, WCD Admin. Order 6-1992 is applicable to this case.

The adaptability factor is based on a comparison of the strength demands of the worker's job at time of injury with the worker's maximum RFC at time of determination. Former OAR 436-35-310(1). RFC is determined from the greatest capacity evidenced by the attending physician's release, the preponderant medical opinion or the strength of any job to which the worker has "returned to work." Former OAR 436-35-270(3)(d)(A) through (C).

"Light work" requires "[l]ifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds." Former OAR 436-35-270(3)(g)(B). "Medium work" requires "[l]ifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds." Former OAR 436-35-270(3)(g)(C).

For those workers determined "to have the RFC to do more than the requirements of one category of RFC, but not the full range of requirements for the next higher category," the classification is established between the two categories. Former OAR 436-35-310(3). In addition, for those workers determined "to have a RFC established between the two categories and also have restrictions, the next lower classification shall be used." Former OAR 436-35-310(4).

Claimant contends that Dr. Zirschky's lifting restrictions of 15 to 20 pounds frequently and 30 to 40 pounds occasionally combined with "other" restrictions, place claimant in the sedentary RFC category, for an adaptability value of 5. We disagree.

Claimant is unable to do the full range of medium work. He is, however, able to do more than light work. Thus, based on strength alone, claimant's RFC is "medium-light." Former OAR 436-35-310(3). When claimant's "medium-light" strength restrictions are "combined" with his "other" restrictions, claimant's maximum RFC is "light." Former OAR 436-35-310(4).

The parties stipulated that claimant's prior strength demands were in the medium category. Therefore, the Referee properly assigned a value of 3 for the adaptability factor. Former OAR 436-35-310(3).

ORDER

The Referee's order dated December 2, 1993 is affirmed.

July 14, 1994 Cite as 46 Van Natta 1466 (1994)

In the Matter of the Compensation of
HENRY A. TERRY, Claimant
WCB Case Nos. 93-03582 & 92-15766
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband and Neidig.

Claimant requests review of that portion of Referee Howell's order that upheld the SAIF Corporation's denial of claimant's neck condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a cervical condition for which he first sought treatment in 1985, undergoing surgery in 1988. In December 1991, while working, claimant fell from a ladder. SAIF accepted claims for injuries to claimant's left foot and low back. Claimant challenges the Referee's conclusion that he failed to prove that the need for treatment of his neck also is compensable. See ORS 656.005(7)(a)(B). Although agreeing with the Referee's application of ORS 656.005(7)(a)(B), claimant asserts that he carried his burden of proof with evidence that the December 1991 fall was the major contributing cause of his disability and need for treatment, citing U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). We agree with claimant.

Dr. Newby, claimant's treating physician, correctly understood that claimant's preexisting cervical condition was substantially quiescent, except for occasional neck pain.. He opined that the December 1991 fall caused a strain or whiplash in claimant's neck, which was a new pathology. The whiplash strain condition combined with claimant's preexisting degenerative cervical condition to cause an increase in symptoms to the point that claimant became disabled and required medical treatment. Thus, Dr. Newby asserted that, although the symptoms were from the preexisting cervical condition, and the treatment was directed solely to those symptoms, the compensable injury is what required claimant to seek treatment, and it is the major contributing cause of his need for treatment. (Ex. 45, pp. 8-11; 18-19; 22-23).

We find no persuasive reasons not to defer to Dr. Newby as the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). Therefore, we find his opinion more persuasive than that of Dr. Tesar, who examined claimant on behalf of SAIF and found that, although the 1991 fall had initially caused a temporary exacerbation of claimant's neck condition, claimant's current symptoms represented a waxing and waning of his preexisting condition and, therefore, his condition was not related to the injury. (Ex. 46).

Under ORS 656.005(7)(a)(B), when a work-related injury combines with a preexisting, noncompensable condition to cause disability or a need for treatment, the worker must show that the injury is the major contributing cause of the disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409, on recon 120 Or App 590 (1993). Based on Dr. Newby's opinion, we find that claimant has met his burden of proof under ORS 656.005(7)(a)(B). Consequently, we conclude that he proved compensability.

Claimant's attorney is entitled to an assessed fee for finally prevailing against SAIF's denial. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review is $3,875, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record at hearing, claimant's appellant's and reply briefs, and claimant's attorney's statement of services), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated August 12, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,875, to be paid by the SAIF Corporation.

Board Member Neidig dissenting.

Citing to U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), the majority concludes that claimant's disability and need for treatment is compensable based on evidence that a 1991 work injury was the "major contributing cause of increasing the symptomatology of claimant's preexisting cervical condition[.]" Because I am convinced that the majority failed to apply ORS 656.005(7)(a)(B) and misconstrues Burtis, I dissent.

Under ORS 656.005(7)(a)(B), when a work-related injury combines with a preexisting, noncompensable condition to cause disability or a need for treatment, the work-related injury is compensable only if it is the major contributing cause of the disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993).

In Burtis, the claimant began experiencing minor neck pain in 1987 and sought medical treatment in March 1989. In December 1989, he was diagnosed as having a chronic cervical strain. The Board held that the claimant's compensable injury was the major contributing cause of his disability and need for treatment, including surgery, and, therefore, he proved compensability under ORS 656.005(7)(a)(B).

The Court of Appeals affirmed. In rejecting the employer's argument that proposed surgery was not compensable because it was for a degenerative disc disease rather than the cervical strain, the court agreed with the Board's reasoning that, whether or not treatment was directed at the degenerative condition, compensability had been proved with medical evidence that the accepted cervical strain was and remained the major contributing cause of the claimant's disability and need for treatment. 120 Or App at 357-58. The court further noted that the "claimant's cervical strain made his degenerative disc disease symptomatic, resulting in the need for the surgery." Id. at 358.

The court also disagreed with the employer's contention that the Board's conclusion was not supported by substantial evidence because, according to the employer, work activities, rather than the accepted injury, caused the degenerative disc disease to be symptomatic. The court found that substantial evidence supported the Board's conclusion that the "claimant's cervical strain, in combination with his degenerative disc disease, is exacerbated by his work activities and is the major contributing cause of his disability and need for treatment," noting that the physicians had diagnosed a chronic cervical strain superimposed on a degenerative disc disease; the strain was directly related to the claimant's employment; the claimant first sought treatment because of his cervical strain; and "[p]rior to his injury, [the] claimant's degenerative disc disease was asymptomatic and required no medical treatment." Id. at 358-59.

In affirming the Board's order, the court referred to evidence that the claimant's previously asymptomatic degenerative condition became symptomatic following his compensable injury. However, the court repeatedly indicated that compensability was proved because the medical evidence showed that the preexisting condition combined with the compensable injury and the major contributing cause of the resultant condition was the compensable injury. Id. at 356-59. The holding in Burtis, therefore, is consistent with the court's interpretation of ORS 656.005(7)(a)(B) contained in Nazari.

The medical evidence in this case falls far short of this standard. Claimant began experiencing neck symptoms during the early 1980's and, by 1985, was diagnosed with a herniated disc. In 1988, he underwent surgery at C6-7. In December 1991, claimant fell from a ladder at work. As explained in the majority's order and by the Referee, the most favorable evidence shows that claimant's neck symptoms following his injury were in major part caused by his preexisting condition but that the December 1991 injury was the major contributing cause of his increased symptomatology.

In concluding that claimant proved compensability, the majority holds that ORS 656.005(7)(a)(B) is satisfied merely with a showing that a compensable injury increases the symptomatology of a preexisting condition. Such an approach is contrary to the provision in ORS 656.005(7)(a)(B) that a "resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." (Emphasis added.) Based on such language, compensability is established when the compensable injury is the major contributing cause of the entire resultant condition and not merely increased symptoms from the preexisting condition.

Furthermore, as explained above, there is no support in Burtis for the majority's misapplication of ORS 656.005(7)(a)(B) since that case endorsed the finding of compensability based on medical evidence showing that the compensable injury was the major contributing cause of the claimant's resultant condition. Moreover, even if I could accept a different interpretation of Burtis, the facts in that case concerned a previously asymptomatic degenerative disc disease that became symptomatic following claimant's compensable injury. Consistent with such facts, the Board previously has applied Burtis only to preexisting asymptomatic conditions. See Richard N. Wigert, 46 Van Natta 484 (1994); Albert H. Olson, 46 Van Natta 172 (1994); Kenneth W. Devaney, 45 Van Natta 2333 (1993); Lynda K. Webber, 45 Van Natta 2106 (1993); David F. Campbell, 45 Van Natta 2024 (1993). Here, claimant was diagnosed with a cervical condition long before his compensable injury, even undergoing surgery in 1988. Furthermore, although he was not seeking treatment for this condition at the time of his injury, the record shows that he was experiencing some neck pain. Thus, without explanation, the majority is now extending the "Burtis rule" to preexisting symptomatic conditions.

In conclusion, the medical evidence in this case shows that claimant's "resultant condition" for which he seeks treatment is in major part caused by his preexisting cervical condition. Therefore, his claim fails under ORS 656.005(7)(a)(B). Evidence that symptoms from his preexisting condition were increased by his compensable injury and the Burtis case do not dictate a contrary result, especially in light of the fact that claimant's preexisting condition had been symptomatic and extensively treated before his compensable injury.

In the Matter of the Compensation of
BETTY V. WEST, Claimant
WCB Case No. 93-03052
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Menashe's order that: (1) set aside its denial of claimant's occupational disease claim for a right arm condition; and (2) assessed a penalty for its allegedly unreasonable delay in providing discovery. On review, the issues are compensability and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions and opinion concerning this issue.

Penalties

The Referee assessed a penalty under ORS 656.262(10) for the insurer's delay in disclosing Dr. Nolan's April 24, 1992 handwritten letter to the insurer's attorney. In the letter, Dr. Nolan wrote that it would be "tough" to deny a work claim for radial nerve palsy. (Ex. 74-43). Claimant's attorney did not discover the letter until Dr. Nolan's May 4, 1993 deposition. The Referee found that the insurer's failure to timely disclose the document constituted an unreasonable delay or refusal to pay compensation.

In order to assess a penalty, there must be amounts of compensation "then due" upon which to base the penalty. See ORS 56.262(10)(a); Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989). Here, at the time of the discovery violation, claimant's claim was in denied status, and no compensation was "then due." Accordingly, no penalty is authorized. See id.

However, attorney fees under ORS 656.382(1) do not depend on "amounts then due"; such fees may be assessed for an unreasonable resistance to the payment of compensation. See Eastmoreland Hospital v. Reeves, supra. The insurer's failure to timely disclose Dr. Nolan's letter was unexplained and, therefore, unreasonable. Inasmuch as the letter provided a basis for challenging Dr. Nolan's final opinion (that the condition is not work-related), we also find that the insurer unreasonably resisted compensation payable after issuance of its denials on February 1, 1993, and March 15, 1993 (as a result of the Referee's order setting aside the denials). Accordingly, in lieu of the Referee's penalty assessment, we assess an attorney fee under ORS 656.382(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for the insurer's discovery violation is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Attorney Fee on Review

Claimant is also entitled to an assessed attorney fee for prevailing over the insurer's request for review concerning the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,400, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 24, 1993 is modified in part and affirmed in part. In lieu of the Referee's penalty assessment, claimant is awarded an assessed attorney fee of $500, to be paid by the insurer. The Referee's order is otherwise affirmed. Claimant's attorney is awarded $1,400 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
KEVIN KOSER, Claimant
WCB Case No. 93-09483
ORDER ON REVIEW
Gerald R. Hayes, Claimant Attorney
Saif Legal Dept., Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Referee Emerson's order that set aside its denial, on behalf of the Inmate Injury Fund, of claimant's cervical spine injury claim. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation.

SAIF argues that the Referee misinterpreted ORS 656.005(7)(a)(B) and that claimant must prove the injury was the major contributing cause of the "resultant condition" rather than the major contributing cause of his disability or need for treatment. We disagree.

The Court of Appeals has interpreted ORS 656.005(7)(a)(B) and held that a work-related injury which combines with a preexisting condition to cause disability or a need for treatment is compensable only if it is the major contributing cause of the disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993). The Referee correctly applied ORS 656.005(7)(a)(B). Furthermore, we agree with the Referee that the unrebutted opinion of claimant's treating neurosurgeon establishes that the work injury was the major contributing cause of claimant's disability and need for treatment.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $750, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 29, 1993 is affirmed. For services on review, claimant's attorney is awarded a fee of $750, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
VERNA N. HESS, Claimant
WCB Case No. 91-16856
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee McWilliams' order which affirmed an Order on Reconsideration that reduced claimant's unscheduled permanent partial disability for a right shoulder injury from 13 percent (41.6 degrees) to 10 percent (32 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction and supplementation.

The April 8, 1993 Order on Reconsideration did not affirm the January 19, 1993 corrected Notice of Closure but, rather, reduced the award given by the corrected Notice of Closure.

At hearing, the parties stipulated to the following values for vocational factors: age, 1; education, 1; adaptability, 4. The parties agreed that the only issue to be decided by the Referee was the impairment factor. (Tr. 3, 4).

CONCLUSIONS OF LAW AND OPINION

Claimant contends and, in its brief, SAIF agrees, that the Referee erred in reducing the adaptability factor to 2, when the parties had stipulated to a value of 4.

We have previously stated that it is our policy to encourage parties to resolve disputed issues and to approve agreements reached by the parties, unless it appears that the agreement was obtained by a party's unfair advantage over the other. Dana W. Wood, 44 Van Natta 2241 (1992). Here, because we find no evidence to support an unfairly obtained stipulation, the extent of claimant's permanent disability will be calculated using an adaptability value of 4.

Claimant argues that the Referee erred by using an evidentiary source outside the record in determining that claimant had not established the nature of nerve damage necessary to assign an impairment rating for loss of muscle strength of claimant's supraspinatus muscle. OAR 436-35-350(3). We agree with the Referee's conclusion, but for the following reason.

OAR 436-35-350(3) states:

> "Injuries to a unilateral specific named peripheral nerve with resultant loss of strength shall be determined based upon a preponderance of medical opinion that reports loss of strength pursuant to 436-35-007(14) and establishes which specific named peripheral nerve is involved." (Emphasis added).

Here, claimant's treating physician, Dr. Kuller, stated that claimant has "a loss [of strength] of 1 grade of resisted supraspinatus testing." (Ex. 48). However, Dr. Kuller's report does not establish which specific nerve is involved in causing the loss of strength. Therefore, we conclude that claimant has not proven entitlement to a permanent disability award for loss of strength pursuant to OAR 436-35-350(3).[1]

Claimant further argues that she is entitled to a permanent disability award for a partial resection of her clavicle. Claimant contends that, during surgery for an acromioplasty and right shoulder exploration, the sentence referring to "further bone" being removed meant bone removal from the clavicle because the sentence immediately followed the description of the removal of spurring on the clavical. (Ex. 18). We do not agree.

Claimant's surgery was for an acromioplasty, and the surgical report states in relevant part:

> "It was noted that there was a large amount of acromion with spurring anteriorly and inferiorly, all of which was noted to impinge severely on the cuff with shoulder movement. The anterior rim of the acromion was removed flush with the distal clavicle following which the inferior acromion was removed using osteotome and mallot and also removing a small ridge of spurring on the inferior lip of the clavicle at the AC joint. Further bone was removed until the shoulder was felt to have excellent amount of room with no further impingement noted on range of motion. I was able to comfortably hold an index finger under the acromion throughout the range at this point." (Ex. 18).

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[1] Additionally, the medical arbiter specifically stated that claimant has 5/5 strength in the upper arm and shoulder areas. (Ex. 51-2).

This portion of the surgical report specifically refers to removal of bone from the anterior rim of the acromion and the inferior acromion. The removal of a small ridge of spurring on the clavical is incidental to the acromioplasty being done by the surgeon. Accordingly, we interpret the reference to further bone being removed as being a reference to further removal of the acromion until no further impingement was noted. Therefore, we agree with the Referee that the surgeon did not remove anything inherent to the clavicle. Accordingly, claimant is not entitled to a permanent disability award for resection of the clavicle.

In calculating claimant's total impairment, the parties agree that claimant is entitled to 5 percent impairment for partial resection of the acromion. OAR 436-35-330(14). The parties further agree that claimant is entitled to a total of 1 percent impairment for loss of abduction and adduction in the right shoulder. OAR 436-35-330(5) and (7). Claimant's impairment values are combined for a total impairment of 6 percent. OAR 436-35-007(10).

In calculating the total permanent disability award, the age factor (1) is added to the education value (1) for a total of 2. OAR 436-35-280(4). That figure is multiplied by the adaptability factor (4) for a total of 8. OAR 436-35-280(6). That result is added to the impairment value (6) for a total of 14. OAR 436-35-280(7). Accordingly, claimant's total unscheduled permanent disability award for her right shoulder injury is 14 percent.

Attorney fee

We further conclude that, inasmuch as this order increases claimant's permanent disability award, claimant's counsel is entitled to an attorney fee payable from the increased compensation. ORS 656.386(2). In awarding an attorney fee, we rely upon our recently issued decision in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994). In Volk, the issue presented was whether an insurer was required to pay an "out-of-compensation" attorney fee award to a claimant's attorney, where the permanent disability award (including the portion which represented the attorney fee award), had already been paid to the claimant. We concluded that the claimant's counsel was entitled to an attorney fee as the attorney was instrumental in establishing the claimant's entitlement to a permanent disability award and had obtained a "substantive increase" in the claimant's permanent disability award.

Similarly, in the present case, we find that claimant's attorney has been instrumental in obtaining a substantive increase in claimant's permanent disability (4 percent unscheduled permanent disability; 14 percent - 10 percent granted by the Referee's order). Consequently, claimant's attorney is entitled to an attorney fee equal to 25 percent of this increased compensation, not to exceed $3,800. ORS 656.386(2); OAR 438-15-055(1). In the event that this substantively increased temporary disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Volk, supra.

ORDER

The Referee's order dated September 8, 1993 is modified. In addition to the Referee's award of 10 percent (32 degrees) unscheduled permanent disability, claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability for a total award of unscheduled permanent disability to date of 14 percent (44.8 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event that this increased compensation has already been paid to claimant, claimant's attorney is authorized to seek recovery of the fee in the manner prescribed in Jane Volk, supra.

In the Matter of the Compensation of
BARBARA ADDINGTON, Claimant
WCB Case Nos. 93-02647 & 93-02646
ORDER ON REVIEW
Bryant, Emerson, et al., Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The insurer requests review of that portion of Referee Michael V. Johnson's order which reclassified claimant's November 1991 injury claim from nondisabling to disabling. On review, the issue is reclassification. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On February 14, 1992, Dr. Cross, claimant's treating physician, found that claimant had tenderness in the left SI joint, and that ranges of motion, reflexes, and strength were normal. Dr. Cross diagnosed claimant's condition as a chronic SI strain. He reported that claimant was medically stationary and that no further treatment was recommended, but that claimant "still had a physical problem that will probably be present for a long time." Dr. Cross recommended lifting, standing, and walking restrictions.

The Referee determined that Dr. Cross' February 14, 1992 chart note was a claim, made on claimant's behalf, for redesignation of claimant's injury from nondisabling to disabling. The Referee concluded that Dr. Cross' report was a clear statement that claimant would be entitled to an award of permanent disability under the standards. The Referee, therefore, ordered the insurer to notify the Director, pursuant to ORS 656.277(1), that claimant's nondisabling injury had become disabling. We disagree that claimant's November 1991 injury is disabling and reverse.

ORS 656.277 provides that claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

> "(1) If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the director for determination pursuant to ORS 656.268."

We find that Dr. Cross' February 14, 1992 chart note is insufficient notice that claimant's nondisabling injury is disabling. Because claimant is medically stationary, she must prove that she will be entitled to a permanent disability award under the standards. OAR 436-30-045(5). Dr. Cross' statement that claimant has a physical problem that will be present for a long time is insufficient to establish that claimant suffers impairment or that her condition is permanent. Rather, the doctor's description of claimant's condition implies an eventual resolution of her pain complaints. See David A. Kamp, 46 Van Natta 389 (1994) (diagnoses of chronic neck and shoulder conditions did not establish that the claimant was entitled to chronic condition impairment).

Dr. Cross subsequently explained that he recommended lifting, standing, and walking restrictions because claimant's chronic sacroiliac strain caused a waxing and waning of symptoms. Because these restrictions were to prevent an increase in symptoms, they are also insufficient to establish permanent impairment. See Rae L. Holzapfel, 45 Van Natta 1748 (1993) (doctors' recommendations that the claimant avoid repetitive work in order to prevent an increase in symptoms was insufficient to establish a permanent and chronic impairment).

Dr. Gabr, neurologist, and Dr. Duff, orthopedic surgeon, performed an independent medical exam on April 24, 1993. They noted that claimant had been working for the last week and that her back continued to bother her, but did not interfere with her work duties. The doctors concluded, based on examination, that although claimant had subjective complaints of pain, she had no permanent impairment.

Pain is considered to the extent that it results in measurable impairment. OAR 436-350-010(2). If there is no measurable impairment, no award of permanent impairment shall be allowed. OAR 436-35-270. Claimant's testimony that her pain limited her ability to work is insufficient to establish impairment under the standards. OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991). The medical evidence fails to establish that claimant's November 1991 injury has resulted in permanent impairment. Thus, we conclude, that under the standards, claimant will not be entitled to a permanent disability award. Claimant, therefore, is not entitled to reclassification of her claim. Accordingly, claimant's claim shall remain classified as "nondisabling."

ORDER

The Referee's order dated August 31, 1993 is reversed in part and affirmed in part. Those portions of the order that directed the insurer to report claimant's claim to the Director as disabling and awarded claimant's counsel an out-of-compensation attorney fee are reversed. The remainder of the order is affirmed

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In the Matter of the Compensation of
ERASMO N. AGUILAR, Claimant
WCB Case No. 92-11834
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to its December 30, 1993 order, the court has remanded for reconsideration of our prior order that affirmed a Referee's order that affirmed a Director's order finding that claimant was not eligible for vocational assistance. Specifically, we have been directed to reconsider our decision in light of Colclasure v. Washington County School District No. 48-J, 317 Or 526 (1993).

FINDINGS OF FACT

We adopt the Referee's findings of fact, but not her ultimate findings of fact. In addition, we supplement with the following.

Claimant began working for the employer on August 19, 1991 as a choker setter. Claimant was hired as a permanent full-time employee.

Claimant sustained a compensable low back injury on August 23, 1991.

At the time of his injury, claimant was working 8 hours a day, except Saturdays and Sundays, for $8.00 an hour.

Reciting that claimant's employer at injury had "confirmed" that claimant was a "seasonal" employee, the insurer's rehabilitation consultant found claimant ineligible for vocational assistance on the basis that he possessed the necessary skills and ability to return to a job that paid a wage within 20 percent of his regular work. Claimant requested Director review of the insurer's decision.

The Director found that claimant's at-injury job as a choker setter was "temporary," and applied OAR 436-120-025(1)(b) to calculate claimant's suitable wage. The Director calculated an average weekly wage of $30, based on claimant's total earnings, as reported by the Oregon Employment Division, for the 52 weeks preceding his injury. Because the Director found that claimant was capable of light work and that there existed in substantial numbers work within claimant's physical abilities that required no specific training or experience, the Director concluded that claimant did not have a substantial handicap to employment. Accordingly, the Director concluded that claimant was not entitled to vocational assistance.

Claimant appealed the Director's order to the Hearings Division. A full evidentiary hearing was held.

The Referee found that although there was evidence to the contrary in the record developed before her, there was evidence from which the Director reasonably could have found that claimant was a "seasonal" worker. Therefore, the Referee affirmed the Director's order.

CONCLUSIONS OF LAW AND OPINION

Under ORS 656.340, a worker is eligible for vocational assistance if the worker cannot return to his prior employment or other suitable employment. Among other things, employment is suitable if it produces a wage within 20 percent of the wage currently being paid for employment which is the regular employment for the worker. ORS 656.340(6)(b)(B)(iii).

OAR 436-120-005(6)(a)(A) provides that "[f]or other than full time permanent employment, suitable wage is determined as described in OAR 436-120-025." The relevant portions of OAR 436-120-025 provide:

> "(1) For the purpose of establishing a base wage from which to calculate a suitable wage when a worker's job at the time of injury is other than a full-time permanent job, the following standards apply:
>
> * * *
>
> (b) Seasonal and temporary employment. When the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected, the wage is established by including earned wages and unemployment insurance benefits for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at full time to establish the base wage."

Claimant's employment at injury was as a choker setter. The Director, having concluded that claimant's job at injury was other than full-time permanent, found the job at injury "temporary." The Director then applied OAR 436-120-025(1)(b) to determine claimant's base wage, and concluded that suitable employment was available to claimant at that wage.

Claimant contends that there is no evidence that his job at injury was other than full-time permanent work. Thus, claimant asserts that there is no evidence to support the Director's application of OAR 436-120-025(1)(b) to calculate his suitable wage. The determinative issue for claimant's entitlement to vocational assistance is, therefore, whether his at-injury employment as a choker setter was permanent.

Relying on Richard A. Colclasure, 42 Van Natta 2454 (1990), and Lasley v. Ontario Rendering, 114 Or App 543 (1992), the Referee determined that her scope of review of the Director's order was limited to determining whether the Director's order was subject to modification pursuant to ORS 656.283. Therefore, although the Referee found that there was evidence developed at hearing to the contrary, based upon her understanding that she could modify the Director's order only upon a finding that it was not supported by the record, the Referee declined to determine "how the evidence preponderates." Instead, finding that there was evidence in the record from which the Director reasonably could have found that claimant was a "seasonal" worker, the Referee concluded that the Director's decision did not violate ORS 656.283. Accordingly, the Referee affirmed the Director's order.

Subsequent to the Referee's order, the Supreme Court in Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993), explained the scope of a referee's review of a Director's order. The Court stated that the provisions of ORS 656.283 contemplated, at a minimum, an opportunity to be heard, an opportunity to present and rebut evidence, and a reviewable record. The Court reasoned that where the Director informally investigated and issued an order, the referee's role was to conduct a hearing at which the parties develop a record; on the basis of that record, the referee finds the facts from which to conclude whether, among other things, the Director's decision survives review. The Board then reviews under ORS 656.283(2) upon the record developed before the referee. Colclasure v. Washington County School Dist. No. 48-J, supra, 317 Or at 537.

In accordance with ORS 656.283(2), a worker who is dissatisfied with his vocational assistance must first apply to the Director for administrative review before requesting a hearing. The statute further provides that the decision of the Director may be modified only if it:

"(a) Violates a statute or rule;

"(b) Exceeds the statutory authority of the agency;

"(c) Was made upon unlawful procedure; or

"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

In this case, the procedures conducted at the hearings level comport with this process. The parties developed a record before the Referee. On the basis of that record, the Referee found that there was evidence to support the conclusion that claimant was not hired as a full-time permanent worker. Based on her findings, the Referee then concluded that the Director's decision neither violated a rule or statute nor evidenced an abuse of discretion. Upon reviewing the record developed before the Referee under ORS 656.283(2), however, we reach a different conclusion. See Colclasure v. Washington County School Dist. No. 48-J, supra, 317 Or at 537.

In deciding whether to apply OAR 436-120-025(1)(b), the crucial question is whether claimant's employment is properly considered permanent full-time work. This is a factual issue.

Claimant testified at hearing that at the time of hire, it was his understanding that the position was permanent, in that he was hired to work full days at $8.00 an hour. (Tr. 11, 26). Claimant stated that he expected the job to be ongoing, and that he was never told that the job "was for a time." (Tr. 22). Finally, claimant testified that he would still be working for the employer if he had not been injured. (Tr. 11).

The insurer's rehabilitation consultant concluded, apparently based on a conversation with the employer, that claimant's employment was "seasonal." (Ex. 20). Similarly, the vocational consultant in the Director's Rehabilitation Review Section, apparently in reliance on the insurer's rehabilitation consultant's purported conversation with the employer, also concluded that claimant's employment was "seasonal." However, the record does not support the consultants' conclusions.

We find the most persuasive evidence concerning this issue was the undisputed testimony by claimant. Based on our review of the record, we agree with the Referee's finding that claimant was a credible witness. We are also impressed by the fact that he was the only individual to testify as to the employment circumstances under which he was hired. No employer representative testified. Consequently, we find that the best evidence as to the permanency of claimant's employment is claimant's unrebutted testimony. See Leslie R. Ledford, 46 Van Natta 2 (1994) (where the claimant testified that he was hired for a 40 hour work week at $8.00 an hour, and no employer representative testified, we found the best evidence on the issue of the claimant's employment status was the claimant's credible testimony). Therefore, based on the evidence, we are persuaded that claimant was hired as a full-time permanent employee.

Given the fact that claimant was a permanent full-time employee, we hold that the Director erred by applying OAR 436-120-025(1)(b) to calculate claimant's base wage. That is, the factual situation in this case did not warrant the application of OAR 436-120-025(1)(b). Therefore, we conclude that the Director violated ORS 656.340 by relying on OAR 436-120-025(1)(b) to determine claimant's suitable wage. See ORS 656.283(2)(a). Instead, we find claimant's base wage from which to calculate a suitable wage to be claimant's at-injury wage of $8.00 an hour as a choker setter.

Consequently, using a base wage of $8.00 an hour to calculate suitable employment, claimant would have a substantial handicap to employment. See, e.g., Reyna R. Rolban-Duenez, 46 Van Natta 865, 869 (1994) (at present, the state and federal minimum wage is $4.75 an hour). Therefore, we find the eligibility prerequisites of ORS 656.340 have been satisfied. See ORS 656.340(6)(a) and (b)(B)(iii); OAR 436-120-005(6)(a)(A); OAR 436-120-005(10). Accordingly, because the Director's order countermands eligibility, the order must be modified. ORS 656.283(2).

On reconsideration, therefore, we modify that portion of the Referee's order dated October 15, 1992 that found that claimant was not eligible for vocational assistance. We modify the Director's order to direct the insurer to provide claimant the vocational assistance he would receive based on his at-injury work as a choker setter consistent with this order. The claim is remanded to the insurer for further action consistent with this order.

Inasmuch as this order has resulted in increased compensation, claimant's attorney is awarded 25 percent of that increase not to exceed $3,800, payable directly to the attorney from the insurer. ORS 656.386(2); OAR 438-15-005(1). Claimant is not entitled to an assessed fee for his counsel's services on review in overturning the insurer's denial of vocational assistance. See Simpson v. Skyline Corporation, 108 Or App 721 (1991) (the question of whether a claimant is entitled to vocational assistance concerns only the availability of a certain type of benefits, rather than whether the claimant's condition was caused by his industrial injury); David F. Meissner, 45 Van Natta 249, on recon, 45 Van Natta 384 (1993).

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA J. CORWIN, Claimant
WCB Case No. 93-07300
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of those portions of Referee Myzak's order that: (1) calculated claimant's average weekly wage for purposes of establishing the rate of temporary disability compensation and a base wage for purposes of establishing claimant's eligibility for vocational assistance at the amount of $241.20; and (2) vacated a Director's order that denied vocational eligibility to claimant. Subsequent to the filing of claimant's reply brief, claimant's attorney filed a request for a specific fee for his services on Board review. On review, the issues are rate of temporary disability benefits, eligibility for vocational assistance, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant worked part time as a kitchen aide until February 1987, when she left her employment for personal reasons. From November 1987 to July 1988, claimant worked part time for a home care agency as an in-home health aide. From July 1988 to April 1989, claimant worked both full and part time as an in-home health aide for individual clients. She left this employment for personal reasons. (Ex. 5).

Claimant reentered the work force on March 2, 1992, when she began work for the employer as a Community Integration Specialist for four eight-hour shifts per week. She worked the same shift every day. Her hourly wage was $6.70. (Exs. A, B and E). On May 5, 1992, claimant quit work for personal reasons. (Ex. D and E).

On June 1, 1992, claimant was rehired by the employer to perform the same work at the same wage in a relief position. The employer scheduled her to work three eight-hour shifts in a row with one, two or three days off between shifts, for a total of 18 working days in the month of June. The hours of the shifts varied. Claimant was on call for additional hours up to 40 hours per week. (Exs. F, G; Tr. 10, 11).

Claimant sustained a compensable low back injury on June 4, 1992, approximately two days after she started working, when she was attacked and shoved to the floor by a patient. Claimant worked her next two scheduled days, June 5 and June 8. She was temporarily disabled as a result of her injury and was unable to continue to work.

Claimant's claim was closed by a March 24, 1993 Determination Order that awarded temporary total disability and permanent unscheduled disability. (Ex. 11). SAIF contacted the employer to establish the intent at the time of hire. Because claimant had worked only three days, SAIF averaged the number of hours worked by two other similarly employed individuals to estimate claimant's likely average weekly wage at the time of injury. SAIF calculated claimant's weekly temporary total disability compensation at a rate of $51.73. (Exs. 9A, 11B and 12B).

Based on the employer's characterization of claimant's work on the 801 claim form, SAIF's Vocational Cost Containment Unit concluded that claimant's employment was temporary. (Exs. 1 and 10-1). It also found that claimant's wages reported to the Department of Employment were $1,848.41 for the 52 weeks preceding the injury. Accordingly, SAIF determined that claimant was ineligible for vocational assistance on the ground that she could obtain suitable employment. (Ex 12). Claimant requested Director review of SAIF's decision.

After reviewing the available information, the vocational consultant with the Rehabilitation Review Unit (RRU) concluded that claimant's employment was temporary. The Director relied on OAR 436-120-025(1)(b) to calculate claimant's suitable wage.

Because claimant did not collect unemployment benefits, the Director calculated an average weekly wage based on claimant's total earnings for the 52 weeks preceding her injury. Specifically, the Director divided claimant's total income for that period by 52 and divided the quotient by 40. That calculation resulted in a base wage of 90 cents per hour based on a full-time work week. Because suitable employment was available to claimant at 80 percent of that base wage, the Director concluded that claimant was not entitled to vocational assistance. (Ex. 13).

Claimant appealed the Director's order to the Hearings Division. A full evidentiary hearing was held on October 15, 1993.

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Total Disability Compensation

As a preliminary matter, we note that there were two issues before the Referee: (1) the rate of temporary total disability compensation from the date of injury, and (2) the base wage on which claimant's eligibility for vocational assistance was to be calculated. In her order, the Referee applied OAR 436-60-025 to establish both the rate of temporary total disability compensation and the base wage rate. She concluded that the Director had violated a rule and vacated the Director's order denying vocational eligibility to claimant.

Claimant was employed for less than four weeks. Thus, the Referee correctly applied OAR 436-60-025(5)(a) to establish the intent at time of hire which, in turn, establishes claimant's average weekly wage. See ORS 656.210(2)(c).

Consequently, pursuant to our de novo review authority, we adopt and affirm the Referee's opinion on this issue, with the exception of the first sentence on page 2 and the last paragraph on page 4. We supplement to address SAIF's remaining argument on review.

SAIF contends that the Referee erred in her computation of claimant's average weekly wage. The Referee computed claimant's average weekly wage as follows: $6.70/hour times 8 hours times 18 days divided by 4 weeks (the actual number of weeks in June that claimant was scheduled to work). SAIF argues that, pursuant to OAR 436-60-025(2)(a), claimant's monthly wages should be divided by 4.35 to determine claimant's average weekly wage. We disagree.

OAR 436-60-025(2)(a) establishes the rate of compensation for regularly employed workers who receive monthly wages. Claimant was neither regularly employed nor received monthly wages. Rather, claimant's wages varied in accordance with the number of hours she worked. Consequently, her rate of compensation is required to be computed on the basis of wages determined under OAR 436-60-025(5). As noted above, claimant's wages are based on the intent at the time of hire, which is a factual question. Here, claimant and the employer intended for claimant to work 18 days in the four weeks remaining in June subsequent to claimant's date of hire. The Referee, accordingly, correctly divided by four to establish an average weekly wage of $241.20.[1]

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[1] We note that, in order to establish claimant's temporary total disability benefits, SAIF calculated claimant's average weekly wage as follows. SAIF contacted the employer to establish the intent at the time of hire. The employer provided the information that claimant was "on call." There is no evidence that SAIF contacted the worker as required by OAR 436-60-025(5) and (5)(a).

Because claimant had worked only three days, SAIF averaged the number of hours worked by two other similarly employed individuals to estimate claimant's likely average weekly wage at the time of injury and calculated claimant's weekly temporary total disability compensation at a rate of $51.73. As noted by the Referee, there is no evidence that the workers used to establish claimant's average weekly wage were available for the same number of hours or the varying shifts that claimant was available.

Eligibility for Vocational Assistance

After concluding that claimant was a temporary worker, the Director applied OAR 436-120-025(1)(b) to determine a suitable wage with regard to claimant's eligibility for vocational assistance.

The sole issue raised by claimant on the vocational assistance eligibility matter was the calculation of the base wage used to establish suitable employment. The Referee found that the Director had violated a rule in its calculation of claimant's base wage. Therefore, the Referee vacated the Director's order.

SAIF contends that the Referee applied the wrong rules in determining claimant's base wage for purposes of vocational eligibility. SAIF argues that claimant was a temporary employee whose base wage is established by OAR 436-120-025(1)(b), not OAR 436-60-025(5)(a). In the alternative, SAIF argues that even if claimant is deemed to be a full-time permanent employee, she would not be eligible for vocational assistance, as suitable work is available within 20 percent of a base wage of $221.79.

Based on the record developed before the Referee, we may modify the Director's vocational assistance order only if it (1) violates a statute or rule; (2) exceeds the agency's statutory authority; (3) was made upon unlawful procedure; or (4) constitutes an abuse of discretion. ORS 656.283(2); Colclasure v. Washington Co. School Dist. No. 48-J, 317 Or 526 (1992).

"Suitable employment" means employment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment. ORS 656.340(6)(b)(B)(iii); OAR 436-120-005(6)(a)(A). "Regular employment" means employment of the kind the worker held at the time of the injury or the worker's "customary employment." OAR 436-120-005(6)(b). "Customary employment" is the worker's regular employment when it is other than the job at injury, and is the primary means by which the worker earns a livelihood. Id. For other than full-time, permanent employment, a suitable wage is determined pursuant to OAR 436-120-025. OAR 436-120-005(6)(a)(B).

OAR 436-120-025(1)(b) provides that, when the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected, the wage is established by including earned wages and unemployment insurance benefits for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at a full-time rate to establish the base wage.

Claimant did not hold full-time permanent employment at the time of injury. Furthermore, the record developed before the Referee shows that claimant's employment history between February 1987 and June 1993 was a pattern of part-time work interspersed with periods of absence from the workforce for personal reasons. (Ex. 5). Consequently, we find that claimant's base wage properly is characterized as "customary employment" and, specifically, "seasonal and temporary employment" under OAR 436-120-025(1)(b).

Whether or not claimant actually collected unemployment insurance benefits, her base wage is established by including her earned wages of $1,848.41 and unemployment insurance benefits of zero for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at a full-time rate to establish the base wage. See OAR 436-120-025(1)(b). The Director correctly applied this rule.

Accordingly, we conclude that the Director did not violate a rule in determining a suitable wage and, therefore, reinstate the Director's order finding claimant ineligible for vocational assistance.

Because we found that claimant's regular, customary employment was temporary, and that a rule applied to her situation, we decline to address SAIF's alternative argument.

Attorney Fees

Claimant's attorney filed a request for a specific fee for his services on Board review which is opposed by SAIF. Such a request shall be considered by the Board if the request is included with a timely filed appellate brief under OAR 438-11-020. OAR 438-15-029(2)(a). A request that does not comply with this rule shall not be considered by the Board in determining the amount of a reasonable assessed fee. OAR 438-15-029(4).

Here, claimant's attorney filed the reply brief on January 13, 1994. Subsequently, on February 1, 1994, claimant's attorney filed a statement of services for a specific fee on Board review. Because the request was not included with claimant's timely filed appellate brief, we do not consider it in determining the amount of a reasonable assessed fee for claimant's attorney's services on Board review.

Nevertheless, claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review concerning the temporary disability rate issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the rate of temporary total disability compensation issue is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 15, 1993 is affirmed in part and reversed in part. That portion of the order vacating the Director's order is reversed. The Director's Order dated May 12, 1993 is reinstated and affirmed. The remainder of the order is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
LAWRENCE D. ERSLAND, Claimant
WCB Case Nos. 92-10970, 92-07596 & 92-10969
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Meyers & Radler, Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of that portion of Referee Black's order that directed it to pay a $1,600 assessed attorney fee pursuant to ORS 656.386(1). Claimant cross-requests review of that portion of the Referee's order that upheld SAIF's denials of claimant's claim for a right shoulder condition. On review, the issues are compensability and attorney fees.

We adopt and affirm the Referee's order with the following supplementation.

Attorney Fee

The Referee found claimant's biceps tendon tear of the right arm compensable and assigned responsibility for this condition to Scott Wetzel Services/Albertson's (Albertson's). Although he found Albertson's responsible for the right arm biceps tendon tear, the Referee ordered SAIF to pay the $1,600 assessed attorney fee to claimant's attorney for prevailing against the denial of the biceps tear condition. In reaching this decision, the Referee reasoned that SAIF had denied both compensability and responsibility for claimant's right upper extremity conditions, whereas Albertson's had denied only responsibility for the conditions. On this basis, the Referee found that under Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993), SAIF, as the insurer that placed compensability in issue, was responsible for paying the attorney fee.

On review, SAIF first contends that its three denials deny only the right shoulder impingement condition. SAIF acknowledges that Exhibit 50 refers to the ruptured biceps tendon, but argues that the document is only a disclaimer of responsibility and not a denial of a claim for the ruptured biceps tendon. At hearing, claimant's attorney stated that the issues were compensability and responsibility for two conditions: rupture of the biceps tendon and impingement of the right shoulder. (Tr. 3-4). SAIF's attorney agreed with claimant's attorney's statement of the issues. (Tr. 4). We interpret this statement as an acknowledgment that SAIF denied the ruptured right biceps tendon as well as the right shoulder impingement.

In any case, assuming that the scope of SAIF's denial does not include the biceps tendon rupture, we alternatively find that SAIF was presented with a claim for the tendon rupture and "de facto" denied that claim. In this regard, the chart notes and reports of Dr. Straub, claimant's treating physician, constitute a claim for compensation. In particular, Dr. Straub wrote a letter to SAIF on May 21, 1992 relating claimant's biceps tendon tear to his work at SAIF's insured. Dr. Straub's chart notes also relate claimant's biceps tendon tear to the injury at SAIF's insured. Thus, by November 16, 1992, the date of hearing, the 90 days in which to accept or deny the claim had run and the claim was deemed "de facto" denied. Safeway Stores, Inc. v. Smith, 117 Or App 224 (1993); Barr v. EBI Companies, 88 Or App 132 (1987).

Based on the record, we conclude that SAIF denied claimant's claim for a right biceps tendon tear. Accordingly, we affirm the Referee's award of a $1,600 attorney fee.

Compensability of Right Shoulder Condition

The Referee analyzed the compensability of claimant's right shoulder condition against SAIF as an aggravation of the 1987 and 1990 compensable injury claims. In his order, the Referee found that claimant had not raised an occupational disease theory at hearing. In his cross-reply brief on Board review, claimant asserts that his claim is not an "occupational disease" claim. Rather, claimant argues that his condition is related to the 1990 injury. Accordingly, based on claimant's assertions that he is not raising an occupational disease theory, we need not address an occupational disease claim.

ORDER

The Referee's order dated May 21, 1993, as reconsidered August 16, 1993, is affirmed.

In the Matter of the Compensation of
JASON HALLEY, Claimant
WCB Case No. 93-08628
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Podnar's order that found that the insurer properly paid claimant temporary disability benefits based on his wage at the time of injury. On review, the issue is the rate of temporary disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was hired to work at the rate of $12 per hour and was paid that wage for the first six days of work. On the seventh work day, claimant and the employer agreed to reduce the wage to $10 per hour. Later that day, claimant sustained a compensable injury.

The insurer calculated claimant's time loss based on a wage of $10 per hour. Based on ORS 656.210, the Referee agreed that the insurer properly calculated the rate of claimant's temporary disability benefits since claimant was working at $10 per hour at the time of his injury. Claimant challenges this conclusion, asserting that the rate of his benefits should be calculated according to OAR 436-60-025(5)(a) and, therefore, the wage at the time of hire should determine the rate of his time loss.

Temporary disability benefits for "regularly employed" workers is based on the wage at the time of injury. ORS 656.210(2)(a)(A). "Regularly employed" means actual employment or availability for such employment. ORS 656.210(2)(c). However, for workers not regularly employed and whose remuneration is not based on daily or weekly wages, the director may adopt rules for establishing the worker's weekly wage. Id. Even though regularly employed, a worker who is paid on other than a daily or weekly basis can be subject to a Director's rule prescribing the method for establishing the worker's weekly wage. Lowry v. Du Log, Inc., 99 Or App 459, 462 (1989).

Although we do not necessarily find that claimant was not "regularly employed", because he was paid on an hourly basis, claimant may be subject to a Director's rule. Furthermore, we agree with claimant that his benefits properly are calculated under OAR 436-60-025(5)(a), which applies to workers paid "varying wages." In particular, because claimant's wages initially were paid at $12 per hour and then changed to $10 per hour, we agree that he was paid "varying wages", and, therefore, comes under the rule.

Under OAR 436-60-025(5)(a), when workers have been employed less than four weeks, rate of temporary disability benefits is based on the intent at the time of hire. Khampeng Thammasouk, 45 Van Natta 487 (1993). According to the facts found by the Referee, which we have adopted, claimant was hired to work at the rate of $12 per hour. We find such fact shows that the intent at hire was to pay claimant $12 per hour. Thus, we conclude that claimant's average weekly earnings properly is based on the rate of $12 per hour. See OAR 436-60-025(5).

ORDER

The Referee's order dated November 23, 1993 is modified. Claimant is entitled to temporary total disability benefits based on a rate of $12 per hour. Claimant's attorney is entitled to 25 percent of the increased compensation created by this order, not to exceed $3,800.

July 20, 1994 Cite as 46 Van Natta 1483 (1994)

In the Matter of the Compensation of
NOE BARRERA-ORTIZ, Claimant
WCB Case No. 93-07080
ORDER ON REVIEW
Schoenfeld, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Davis' order which set aside a Notice of Closure and Order on Reconsideration as prematurely issued. The employer also moves to remand to the Referee for consideration of additional evidence. On review, the issues are motion for remand and premature closure.

We adopt and affirm the Referee's order, with the following supplementation.

On review, the employer objects to the Referee's failure to admit into evidence an October 8, 1993 Director's order finding that the surgery proposed by Dr. Nash for this claimant is not appropriate. The employer asks the Board to remand this case to the Referee for consideration of the Director's order.

While this matter was pending our review, the employer filed another motion to remand to consider the July 1993 report of Dr. Thomas, which the employer had only recently received. The employer asserts the report is relevant to the premature closure issue, inasmuch as it addresses the motivation for and likely impact of surgery. The employer also alleges that claimant's counsel improperly concealed the report, since it was addressed to claimant's counsel but was never produced in discovery. Claimant's counsel responds that he never received the report from the doctor because it was misaddressed. Moreover, claimant contends that the report, even if considered, would not affect the outcome of this case.

Having received claimant's response to the employer's recent motion, we proceed to consider the merits of both motions for remand.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence was not obtainable at the time of hearing and is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988). We examine the proposed evidence only to determine if remand would be appropriate.

The Referee declined to admit the Director's order because the Director had no jurisdiction to consider the proposed surgery request under ORS 656.327. Jefferson v. Sam's Cafe, 123 Or App 464 (1993). The Referee reasoned that, as a result, the Director's order was void and could not be considered.

We agree that the Director's authority to issue such a decision is extremely questionable, and we do not accept the Director's decision to be a valid order. See SAIF v. Roles, 111 Or App 597, 601, rev den 314 Or 391 (1992) (when tribunal rendering judgment has no subject matter jurisdiction, the judgment is void; tribunal has subject matter jurisdiction when it has authority to make inquiry and to do something about the dispute). Inasmuch as the Director's order is void, we find that it has no probative value.

Moreover, there is no reasonable likelihood that consideration of the Director's order would affect the outcome of this case. A determination regarding a surgery dispute is of minimal relevance to the premature closure issue because that issue does not turn on the appropriateness of surgery but, rather, on whether claimant was, in February 1993, likely to further improve with either medical treatment or the passage of time. Therefore, we find no compelling reason to justify remand to the Referee for consideration of the Director's order.

We also find no compelling reason to justify remand to the Referee for consideration of Dr. Thomas' July 1993 report. The issue before the Referee was whether claimant was medically stationary at the time of claim closure in February 1993. Dr. Thomas discusses claimant's condition and treatment options as of his examination in July 1993. He does not address claimant's condition in February 1993. Therefore, even if the report were admitted, it is unlikely to affect the outcome of the case, since it does not address claimant's condition at the relevant time.[1]

Under these circumstances, we find no compelling reason to justify remanding this case to the Referee. Consequently, the employer's motions to remand are denied.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and response to the employer's motion), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated November 18, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the self-insured employer.

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[1] The employer also suggests that the case should be remanded to the Referee to determine whether claimant's counsel's failure to provide discovery of the document warrants the imposition of sanctions. In response to the employer's motion, claimant's counsel indicates that he never received the report from Dr. Thomas, pointing out that the letter was wrongly addressed. Under such circumstances, we do not find a compelling reason to remand to the Referee.

In the Matter of the Compensation of
DAVID BOTTOM, Claimant
WCB Case No. 93-05990
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Hall, Westerband and Haynes.

Claimant requests review of Referee Neal's order that upheld the insurer's denial of claimant's right knee injury claim. On review, the issue is whether claimant's injury arose out of and in the course of employment. We reverse.

FINDINGS OF FACT

Claimant works for the employer as a freight unloader.

On February 5, 1993, claimant visited with friends and drank a 32-ounce beer before work. While claimant was on his way to work, a police officer stopped claimant's vehicle for running a yellow light, causing claimant to be about 15 minutes late for his shift.

At work, claimant performed warm-up exercises and began unloading freight. About a half hour later, a box fell from an unstable stack, striking claimant's right knee and causing him pain.

The employer transported claimant to a hospital, where claimant received conservative treatment. A blood test revealed the presence of alcohol in claimant's system.

On April 30, 1993, the insurer denied claimant's right knee injury claim.

The employer had a written drug and alcohol policy prohibiting its employees from going or remaining on duty with alcohol or controlled substances in their systems. Claimant was aware of that policy.

CONCLUSIONS OF LAW AND OPINION

Reasoning that claimant's violation of the employer's drug and alcohol policy amounted to overstepping the boundaries of claimant's ultimate work, the Referee found that claimant's right knee injury was not compensable. We disagree.

The parties do not dispute that claimant was injured while performing his regular work as a freight unloader, that the injury occurred on the employer's premises during regular work hours and that claimant's conduct at the time of injury was for the employer's benefit. They also do not dispute that claimant's activities at the time of injury were contemplated by the employer and employee, that the employer directed or acquiesced in those activities and that claimant was not on a personal mission, and that the risk of injury from a falling box was simply an ordinary risk of claimant's employment.

Furthermore, there is no evidence that claimant's pre-work alcohol consumption in any way caused his injury. Assuming, arguendo, that claimant violated the employer's drug and alcohol policy, we still find no evidence in this record that such a violation contributed to the cause of claimant's injury.

The only question presented by this case is whether, in the absence of any causal connection between claimant's drinking and his knee injury, violation of the employer's drug and alcohol policy constituted misconduct sufficient to take claimant's injury out of the course and scope of his employment. For the following reasons, we conclude that the answer to that question is "no."

This is a case of first impression. The parties agree that Underwood v. Pendleton Grain Growers, 112 Or App 170 (1992), is factually distinguishable. There, the court held that, where the claimant had consumed a large quantity of alcohol and barbiturates during a 4 1/2 hour nonbusiness delay, the claimant's injury during a subsequent automobile accident did not occur in the course of employment. In reaching that decision, the court focused on the facts that the claimant had been expressly prohibited from carrying out the employer's business after consuming alcohol or drugs and the length of the nonbusiness deviation and nature of the claimant's acts. Id. at 173-74. Here, in

contrast, we must determine whether violation of an employer's drug and alcohol policy is, by itself, a sufficient basis for us to conclude that the claimant's injury did not occur in the course of his employment.[1]

Before we analyze that issue, we wish to clarify that this is a "course and scope" case. It is not an ORS 656.005(7)(b)(C) causation case. See Grace L. Walker, 45 Van Natta 1273 (1993), aff'd mem Walker v. Danner Shoe Manufacturing, 126 Or App 313 (1994) (ORS 656.005(7)(b)(C) precludes compensability where a claimant has otherwise established that the injury arose out of and in the course of employment if the employer establishes that the major contributing cause of the claimant's injury is alcohol or unlawful drug consumption (unless the employer permitted, encouraged or had actual knowledge of such consumption)).[2] Indeed, the insurer concedes that there is no evidence that claimant's injuries were caused by his alcohol consumption; to the contrary, the evidence establishes that claimant's injury was caused solely by a box that fell on him through no fault of his own.

The test for determining whether an employee's misconduct involved activities that are outside the course and scope of employment is stated by Professor Larson:

> "When misconduct involves a prohibited overstepping of the boundaries defining the ultimate work to be done by the claimant, the prohibited act is outside the course of employment. But when misconduct involves a violation of regulations or prohibitions relating to the method of accomplishing that ultimate work, the act remains within the course of employment." 1A Larson, Workmen's Compensation Law 6-8, § 31.00 (1985) (hereinafter, "section 31.00") (emphasis in original).

Both this Board and the Court of Appeals have adopted this rule to determine whether a worker's misconduct involved activities that are outside the course and scope of employment. See Davis v. R & R Truck Brokers, 112 Or App 485 (1992); Patterson v. SAIF, 64 Or App 652 (1983); Michael Thornton, 45 Van Natta 743 (1993).

In Patterson, the claimant was a security guard for the employer, Oregon Health Sciences University. The employer had a rule prohibiting the transport of unwanted persons beyond the edge of the employer's premises. Although the claimant knew of this rule, he transported an unruly patient to downtown Portland, at which point he was injured. The employer argued that, because the claimant was injured while he deliberately disobeyed the employer's rule, the claimant's injury did not arise out of and in the course of employment and, hence, was not compensable.

The court disagreed, concluding that the claimant's injury was sufficiently work related to be compensable. The court said:

> "[The claimant] was injured while he was executing the assigned task of removing an unruly patient from the employer's premises. His disregard of the employer's rules was deliberate but did not involve a prohibited overstepping of the boundaries defining his ultimate job responsibilities. Rather, his misconduct involved a violation of the employer's rules governing the method of accomplishing his ultimate work, and therefore, he remained within the scope of his employment. See 1A Larson, Workmen's Compensation Law 6-7, § 31.00 (1979).

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[1] This case is also distinguishable from Faessler v. Turney, 125 Or App 134 (1993). There, the Court of Appeals held that the claimant's injury, which happened while he was intoxicated, occurred within the course and scope of his employment. Although the employer had an informal no-alcohol policy, that policy was not expressly communicated to the claimant. Therefore, the court analyzed the issue under the seven-factor test of Jordon v. Western Electric, 1 Or App 441, 443-44 (1970). Focusing particularly on the employer acquiescence factor, the court concluded that there was substantial evidence that the employer had acquiesced in the claimant's working while intoxicated. Faessler, supra, 125 Or App at 138. In the instant case, the evidence establishes that claimant was aware of the employer's drug and alcohol policy. On that basis, we find Faessler distinguishable.

[2] Claimant argues that ORS 656.005(7)(b)(C) was intended to preempt all other "alcohol defenses." That argument is not well-taken. Professor Larson recognizes that the enactment of a specific intoxication defense raises the argument that the legislature meant that defense to be the exclusive defense in intoxication cases. 1A Larson, Workmen's Compensation Law, 6-87, § 34.22 n 18. Nevertheless, because this Board and the Court of Appeals have continued to address alcohol-related issues in the course and scope context, see Underwood v. Pendleton Grain Growers, supra, Faessler v. Turney, supra n 1, and because claimant has not provided us with any indication that the legislature intended to create an exclusive defense, we conclude that claimant's argument fails.

> "Because [the carrier] concedes that the dispositive misconduct here is the prohibited act of leaving the premises * * *, [the] claimant's misconduct is nothing more than disobedience to specific instructions limiting the sphere of the execution of his employment responsibilities. Because we find that misconduct to be a mere violation of the designated method of execution of his ultimate job duty, the resulting injury is sufficiently work-related to be compensable." Patterson v. SAIF, supra, 64 Or App at 565 (emphasis in original).

In Davis v. R & R Truck Brokers, supra, the claimant, a truck driver, picked up a load for transport from Vancouver, Washington to Grants Pass, Oregon. When the claimant called the employer from Vancouver, the employer instructed the claimant not to complete the trip but to return the truck to the employer's yard in Turner, Oregon. The claimant disobeyed the directive and, after picking up three passengers, traveled further southbound on I-5. North of Grants Pass, the truck flipped over and claimant was injured.

The employer denied the claim, arguing that, by failing to return the truck to Turner as directed, the claimant had left the course of his employment. The court agreed. Relying on section 31.00 of Professor Larson's treatise, the court concluded that claimant's conduct was

> "more than a violation of a regulation or prohibition relating to the method of accomplishing his work. He was specifically told to return the truck and to stop working. Instead he refused to do either and continued on toward Grants Pass, contrary to his job responsibilities. Claimant overstepped the boundaries of the work that he was to do for employer." Davis, supra, 112 Or App at 491.

Similarly, in Michael Thornton, 45 Van Natta 743 (1993), we concluded that the claimant's violation of the employer's specific direction not to work on the day of the injury constituted more than a violation of a regulation or prohibition relating to the method of accomplishing his work. Therefore, we concluded that, when the claimant was injured at the worksite, he had overstepped the boundaries of the work that he was to do for the employer. Id. at 744.

Here, although claimant apparently violated the employer's drug and alcohol policy, we conclude that claimant's misconduct involved a violation of a regulation or prohibition relating to the method of accomplishing his work. As in Patterson, claimant was injured while he was executing an assigned work task; viz., unloading freight. His disregard of the employer's no-alcohol rule was deliberate but did not involve a prohibited overstepping of the boundaries defining his ultimate freight unloading responsibilities. That is, unlike Davis and Thornton, claimant was not performing work that he had expressly been forbidden to perform; to the contrary, he was performing the exact work that he had been hired to perform when, through no fault of his own, he was injured by a falling box. We find that the employer's drug and alcohol policy was a manifestation of its desire that its employees perform their ultimate work responsibilities unencumbered by drugs or alcohol. Therefore, we conclude that claimant's misconduct was a mere violation of the designated method of execution of his ultimate job duties.

In reaching this conclusion, we note the dissent's reference to the last sentence of section 31.00, which provides:

> "Violations of express prohibitions relating to incidental activities, such as seeking personal comfort, as distinguished from activities contributing directly to the accomplishment of the main job, are an interruption of the course of employment." 1A Larson, Workmen's Compensation Law 6-8, § 31.00 (emphasis added).

The dissent argues that, because Professor Larson considers consuming alcohol to be a "personal comfort" activity, see id. at 6-13, § 31.12, we are necessarily bound by the last sentence of section 31.00. We disagree.

First, neither this Board nor any Oregon appellate court has adopted the last sentence of section 31.00 as the law of this state. We decline to adopt it here.

Furthermore, we agree with the reasoning of the New York Court of Appeals case cited by Professor Larson, Burns v. Merritt Engineering Company, 302 NY 131, 96 NE2d 739 (1951). In that case, the claimant was injured when he drank from a bottle marked "gin" that actually contained a poison that a co-worker had put in the bottle as a prank. The employer had a no-alcohol rule. The court concluded that the claimant's injuries were compensable on the ground that the claimant had been an innocent victim of horseplay. The court also said that, even if there had been a violation of the employer's no-alcohol rule, it should be treated no differently than a violation of any other rule designed to improve plant efficiency and to safeguard employees, i.e., a violation of a prohibited method of performing work. Id., 96 NE2d at 740.

We strongly disagree with the dissent's attempt to create a per se rule that, if a claimant has alcohol in her system in violation of an employer's drug and alcohol policy, she is automatically out of the course and scope of her employment. Such a rule would exclude from coverage cases such as this, where an employee was performing assigned work, albeit after consuming alcohol, when, through no fault of his own, and in the absence of any causal connection with his drinking, he is injured. We believe that such a result would be unduly harsh, and we decline to adopt it here.[3]

In reaching our decision in this case, we have carefully considered the public policy and safety concerns underlying drug and alcohol policies such as that present in this case. We encourage employers to continue to ensure safe and productive work environments through the implementation of such policies.

However, we reiterate that there is no contention that claimant's injury was causally related to his rule violation. Claimant did not create the hazard that caused his accident by violating the employer's rule or otherwise. He was simply injured while executing his job duties. Consequently, we conclude that, notwithstanding the employer's and the public's interests in a drug- and alcohol-free workplace, claimant remained within the course and scope of his employment, despite his apparent violation of the employer's drug and alcohol policy. See Patterson v. SAIF, 64 Or App 652 (1983); see also 1A Larson, Workmen's Compensation Law 6-8, § 31.00.

Claimant is entitled to an assessed attorney fee for prevailing on the claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated October 1, 1993 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for further processing according to law. For services at hearing and on review, claimant's counsel is awarded a $3,500 attorney fee, payable by the insurer.

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[3] We also believe that the dissent's analysis would enable employers to easily circumvent the high burden of proof established in ORS 656.005(7)(b)(C). Recognizing the distinction between this case and one analyzed under ORS 656.005(7)(b)(C), see Grace L. Walker, supra, we nevertheless conclude that, because the dissent's proposed rule would likely have a profound impact on cases governed by ORS 656.005(7)(b)(C), one should be required to seek legislative approval of such a rule.

Board Member Haynes dissenting.

The majority holds that because, in its view, the employer's drug and alcohol policy concerned the claimant's method of performing work, claimant's violation of that policy did not take him out of the course and scope of his employment. Because that holding flies in the face of well-reasoned legal principles and common sense, I dissent.

This Board and the Court of Appeals has had occasion to cite Professor Larson for the proposition that

> "[w]hen misconduct involves a prohibited overstepping of the boundaries of the ultimate work to be done by the claimant, the prohibited act is outside the course of employment. But when misconduct involves a violation of regulations or prohibitions related to the

> method of accomplishing that ultimate work, the act remains within the course of employment." 1A Larson, Workmen's Compensation Law 6-8, § 31.00 (1985) (hereinafter, "section 31.00") (emphasis in original).

See Davis v. R & R Truck Brokers, 112 Or App 485 (1992); Patterson v. SAIF, 64 Or App 652 (1983); Michael Thornton, 45 Van Natta 743 (1993).

These cases fail to mention the last sentence of section 31.00, which provides:

> "Violations of express prohibitions relating to incidental activities, such as seeking personal comfort, as distinguished from activities contributing directly to the accomplishment of the main job, are an interruption of the course of employment." 1A Larson, Workmen's Compensation Law 6-8, § 31.00 (emphasis added).

Professor Larson makes it clear that consuming alcohol is considered a "personal comfort" activity. See id. at 6-13, § 31.12. He criticizes a New York Court of Appeals' case, Burns v. Merritt Engineering Company, 302 NY 131, 96 NE2d 739 (1951) (4:3 decision), which concluded that a workers compensation claimant's violation of the employer's no-alcohol rule should be treated no differently that any other violation relating to plant efficiency or employee safety. Larson states that "[t]his reasoning overlooks the basic distinction between prohibited activities that are not part of the work and prohibited methods of doing work. 1A Larson, Workmen's Compensation Law 6-13, § 31.12.

I agree wholeheartedly with Professor Larson. Consuming alcohol and other mind-altering substances is not a part of this (or perhaps, any) claimant's work. The employer's drug and alcohol policy clearly manifested its desire that its employees never work while encumbered by drugs or alcohol. I particularly agree that the consumption of drugs and alcohol is an incidental activity, akin to seeking personal comfort, as distinguished from activities contributing directly to an employee's work. Accordingly, under the last sentence of section 31.00, I would conclude that claimant's violation of the employer's drug and alcohol policy constituted an interruption of the course of employment.

Alternatively, I would conclude that claimant's violation of the employer's drug and alcohol policy constituted misconduct involving a prohibited overstepping of the boundaries defining his ultimate work.

It goes without staying that the ultimate work to be performed by an employee is to do his job to the very best of his ability. An employer has the right to expect that every employee will operate at full capacity with that objective in mind. It follows that rules that are designed to ensure that employees perform at optimal capacity necessarily concern the employees' ultimate work. Because drug and alcohol policies are obviously designed, at least in part, to ensure that employees remain highly productive, in the alternative, I would conclude that claimant's violation of the employer's drug and alcohol policy involved a prohibited overstepping of the boundaries defining his ultimate job responsibilities.

This conclusion is particularly compelling when viewed in light of the facts of this case. Shortly before he began work, claimant consumed 32 ounces of beer. Claimant's blood alcohol level over five hours after the accident was 0.04 grams/dL. (Ex. 3B). Dr. Barton, an occupational health specialist, estimated that, at the time of the accident, claimant's blood alcohol level would have been between 0.10 and 0.14 grams/dL. (Ex. 7-2). I refuse to believe that claimant could have been operating at optimal capacity so encumbered. I likewise refuse to believe that the employer's attempt to prevent claimant from working in such a state did not have a direct bearing on claimant's ultimate work responsibilities.

Finally, I disagree with the majority that legislative sanction would be required before this Board could adopt the approach proposed by this dissent. ORS 656.005(7)(b)(C) precludes compensability where a claimant otherwise has established that the injury arose out of and in the course of employment if the employer establishes that the major contributing cause of the claimant's injury is alcohol consumption (unless the employer permitted, encouraged or had actual knowledge of such consumption). See Grace L. Walker, 45 Van Natta 1273 (1993), aff'd mem Walker v. Danner Shoe Manufacturing, 126 Or App 313 (1994). The statute is silent about whether a claimant leaves the course of her employment by violating her employer's drug and alcohol policy. Accordingly, in view of that legislative silence, I would conclude that resort to common law principles is proper. Since I believe that the common law warrants the analysis and conclusions set forth here, I respectfully dissent.

In the Matter of the Compensation of
ROXANNE R. HEADLEY, Claimant
WCB Case No. 92-05363
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Westerband, Neidig and Hall.

Claimant requests review of Referee Barber's order which: (1) upheld the SAIF Corporation's partial denial of claimant's current condition; and (2) declined to assess penalties or attorney fees for SAIF's allegedly unreasonable denial. Claimant appeals that portion of the Referee's order which upheld SAIF's denial of her current fibromyalgia condition. On review, the issues are compensability and penalties/attorney fees.

We adopt and affirm the Referee's order with the following supplementation.

Compensability

Claimant has accepted claims for bilateral carpal tunnel syndrome (CTS) and bilateral elbow conditions arising from her employment as a net maker and repairer from 1979 to 1988. (Exs. 18, 57). Claimant contends that her current condition, diagnosed as fibromyalgia, is compensably related either to her employment or to her accepted conditions.

Claimant does not contend that her fibromyalgia condition was directly caused by a specific work injury. Therefore, in order to prove compensability, claimant must establish either that work activities were the the major contributing cause of an occupational disease, or that her compensable conditions (bilateral CTS and elbow conditions) are the major contributing cause of her current fibromyalgia condition. ORS 656.802; 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Neither party contends, nor is there any evidence to establish, that claimant's current condition results from the combination of a preexisting condition with the compensable injury. See ORS 656.005(7)(a)(B).

Because of the passage of time between claimant's original claim and the end of her employment in November 1988, and her fibromyalgia claim in 1992, and because of the multiple conditions potentially involved in this case, we find that the causation question is medically complex. Therefore, we require expert medical opinion to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

After our review of the record, we find no medical opinion which establishes that either work activities or the accepted conditions are the major contributing cause of claimant's current fibromyalgia condition.

Claimant relies on the opinion of her treating physician, neurologist Dr. Crumpacker. However, although Dr. Crumpacker diagnosed the fibromyalgia condition and believed it was related to work, he did not identify her work activities, which ended in November 1988, as the major contributing cause of her fibromyalgia condition, nor can we reasonably interpret Dr. Crumpacker's reports as expressing such an opinion. (See Exs. 59AAB, 64B, 66). Moreover, we do not find Dr. Crumpacker's opinion persuasive, because he relies on claimant's history of pain beginning during her employment as the basis for his causation opinion, whereas the medical records do not support such an historical relationship. (Compare Ex. 64B with Exs. 3, 4, 14-1, 17-2). Accordingly, we agree with the Referee's determination that claimant failed to carry her burden of proving compensability of her fibromyalgia condition.

Penalties/Attorney Fees

Claimant also asserts entitlement to penalties and attorney fees for SAIF's allegedly unreasonable denial. Claimant's theory is that SAIF's "current condition" denial effectively cut off further treatment, time loss and other benefits for her compensable conditions, contrary to the court's

prohibition against using a preclosure partial denial to circumvent the orderly closure process. See Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). We disagree, because we find that the Roller and Safstrom prohibition against preclosure denials does not apply in this case.[1]

In its April 10, 1992 partial denial, SAIF defined claimant's "current condition" as the "ancillary conditions" of "thoracic outlet syndrome, cervical degenerative or myofascial component, depression and mixed anxiety, dorsal and xiphoid pain, and diffuse muscular dysfunction syndrome." (Ex. 62). The denial continued:

> "After reviewing the information in your file, we are unable to provide benefits for the 'current condition' and need for disability benefits related thereto, whether it be pre-existing or consequential to the compensable injury; since, neither the compensable injury of 11/22/88, work activities at [the employer], or the accepted condition remains the compensable cause of the current disability, underlying disease, or need for treatment. Therefore, we must issue this partial denial of your 'current condition' and current need for disability benefits.
>
> "SAIF will continue to provide medical benefits related to your accepted conditions of bilateral carpal tunnel syndrome and elbow conditions, however it appears all current need for treatment is related to the now denied 'current condition.'" (Ex. 62).

At hearing, claimant clarified her claim as being for "fibromyalgia," explaining that the symptoms and diagnoses listed in the denial are being caused by a fibromyalgia condition, which claimant asserts is compensable. (Tr. 9; see also Appellant's Brief at 1-2). SAIF affirmed that it is not denying claimant's "current condition" as it relates to the accepted bilateral arm and elbow conditions. (Tr. 11-12).

We agree with the Referee that SAIF's denial is inartfully worded. The reference to "current condition" implies the current status of an accepted condition, whereas SAIF attempted to define claimant's "current condition" as being the aggregate of conditions and symptoms listed in its denial, all of which are different from the accepted conditions. Moreover, regardless of the wording of the denial, the parties actually litigated the compensability of a new and separate condition, fibromyalgia.

Thus, in light of the parties' positions at hearing and on review, we construe SAIF's partial denial as denying a fibromyalgia condition, which is separate from the accepted bilateral arm and elbow conditions. There is no prohibition against issuing a preclosure partial denial of a condition separate from the accepted conditions. Boise Cascade Corp. v. Katzenbach, 307 Or 391 (1989); Johnson v. Spectra Physics, 303 Or 49, 57-58 (1987). That is what SAIF did in this case, albeit inartfully. Therefore, we conclude that SAIF's denial is not unreasonable, because it is not an invalid preclosure denial of an accepted condition.

Claimant also contends that SAIF used the partial denial to improperly terminate her benefits due under the accepted claims. We agree that using a "current condition" partial denial in that manner is prohibited. See United Airlines, Inc. v. Brown, 127 Or App 253 (1994); Roller, supra; Safstrom, supra. However, we find claimant's argument is without merit in this case.

Claimant does not identify any specific benefits that SAIF improperly terminated by use of its partial denial, nor does the record reveal any such benefits. Claimant's accepted bilateral carpal tunnel syndrome condition was in closed status at the time of the partial denial. (See Ex. 57).

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[1] The court recently applied its Roller and Safstrom analysis to prohibit preclosure "resultant condition" denials issued under ORS 656.005(7)(a)(B) while the accepted claim is still open. United Airlines, Inc. v. Brown, 127 Or App 253 (1994). Here, no party contends that SAIF's denial is based on the theory that the compensable injury combined with a preexisting condition, and that the compensable injury is no longer the major contributing cause of the "resultant condition." Therefore, we find that SAIF's partial denial is not prohibited by Brown.

Although claimant's bilateral elbow condition claim was still open, it was closed by Notice of Closure issued July 23, 1992, some 3-1/2 months after SAIF issued the partial denial on April 10, 1992. (Ex. 67). The closure notice awarded no temporary disability benefits during this open period of the claim, and it found claimant to be medically stationary on April 10, 1992, the date of the partial denial. (Id).

Thus, it is not apparent from this record that claimant was entitled to any benefits under her accepted claims, which were or which might have been improperly terminated by SAIF's preclosure partial denial. Claimant may, of course, separately challenge the Notice of Closure. In the case before us, however, we cannot find that SAIF's partial denial was unreasonable because it improperly terminated benefits for claimant's accepted conditions, particularly in light of our determination that the denied fibromyalgia condition is not compensably related to claimant's accepted conditions.

Finally, because we have upheld SAIF's partial denial of the fibromyalgia condition, there is no basis for assessing penalties or attorney fees related to that denial. See Ellis v. McCall Insulation, 308 Or 74, 78 (1989).

ORDER

The Referee's order dated June 15, 1993 is affirmed.

In the Matter of the Compensation of
RAPHAEL IBARRA, Claimant
WCB Case No. 92-11216
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys

Claimant requested reconsideration of our June 2, 1994 Order on Review, which awarded him 13 percent unscheduled permanent disability. On July 1, 1994, we abated the order to consider the motion for reconsideration and granted an opportunity for the insurer to respond. Having received the insurer's response, we proceed with our reconsideration.

Claimant asserts that we miscalculated his adaptability factor in light of England v. Thunderbird, 315 Or 633 (1993). He contends that the Board should have considered his work history prior to the date of injury in determining his adaptability factor.

However, the applicable administrative rule provides that the adaptability factor is based on a comparison of the strength demands of the job at injury with the worker's maximum residual functional capacity. See former OAR 436-35-310(1). The question is whether England requires that we consider claimant's work activities prior to the date of injury. Having fully considered this issue in Michelle Cadigan, 46 Van Natta 307 (1994), we continue to apply former OAR 436-35-310(1) and determine claimant's base functional capacity using his time-of-injury employment. We decline to depart from our holding in Cadigan.[1]

On reconsideration, as supplemented herein, we adhere to and republish our June 2, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Although a signatory to this order, Board Member Hall directs the parties' attention to his dissent in Cadigan, supra.

In the Matter of the Compensation of
CHARLES D. STEPHENS, Claimant
WCB Case No. 93-06272
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Galton's order that upheld the self-insured employer's denial of claimant's low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant's compensable shoulder injury was not the major contributing cause of his low back injury, claimant had failed to prove that his low back condition was compensable. We agree.

The parties stipulated to the following facts. Claimant sustained a compensable disabling injury to both shoulders in 1989. After claimant had several shoulder surgeries, the employer scheduled a medical examination of claimant with Dr. Fuller in 1992. During the examination, Dr. Fuller sent claimant to a radiology clinic to retrieve some x-rays. On his return to Dr. Fuller's office with the x-rays, claimant tripped and fell on a step at the office entrance, thereby injuring his low back. The employer issued a partial denial of claimant's L5-S1 herniated disk.

The issue in this case is whether claimant's low back condition is a "consequence of a compensable injury" and, therefore, subject to the major contributing cause standard of ORS 656.005(7)(a)(A). For the reasons elaborated below, we conclude that the answer to that question is "yes."

In 1990, the legislature amended ORS 656.005(7)(a)(A). Or Laws 1990, ch. 2, § 3. As amended, it provides:

> "A 'compensable injury' is an accidental injury or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." (Emphasis added).

The Court of Appeals has had several occasions to interpret amended ORS 656.005(7)(a)(A). In Albany General Hospital v. Gasperino, 113 Or App 411, 414 (1992), the court explained:

> "[T]he major contributing cause standard of ORS 656.005(7)(a)(A) was not intended to supplant the material contributing cause test for every industrial claim. * * * The distinction is between a condition or need for treatment that is caused by the industrial accident, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the compensable injury. It is the latter that must meet the major contributing cause test." (Footnote omitted; emphasis in original).

Subsequently, in Hicks v. Spectra Physics, 117 Or App 293 (1992), the court was required to determine the compensability of an injury that the claimant had sustained during an automobile accident when she was returning from a treatment for a compensable injury. This Board concluded that the claimant's injuries had arisen as a consequence of a compensable injury, and that the claim was not compensable because the claimant's original compensable injury was not the major contributing cause of the consequential condition. Id. at 295-96.

The court characterized the issue on appeal as whether the phrase in ORS 656.005(7)(a)(A), "consequence of a compensable injury," includes injuries that are the result of activities that would have not been undertaken but for the compensable injury. Id. at 296. After examining the legislative history to the 1990 amendment to ORS 656.005(7)(a)(A), the court concluded that the answer was "no," unless the compensable injury was the major contributing cause of the claimant's consequential condition. Id. at 296-97.

In Hicks, the claimant argued that the injuries she had sustained during the automobile accident were compensable, because they were work related. The court acknowledged that, under Fenton v. SAIF, 87 Or App 78, rev den 304 Or 311 (1987), the claimant would have been correct. However, the court concluded that, by amending ORS 656.005(7)(a)(A) in 1990, the legislature had overruled Fenton. As the court explained, "Under ORS 656.005(7)(a)(A), any injury or condition that is not directly related to the industrial accident is compensable only if the major contributing cause is the compensable injury." Hicks v. Spectra Physics, supra, 117 Or App at 297 (emphasis in original). Concluding that the Board had applied the correct legal standard, the court affirmed the Board's conclusion that the claimant's consequential condition was not compensable. See id.

The court faced a similar situation in Kephart v. Green River Lumber, 118 Or App 76, rev den 317 Or 272 (1993). In that case, the claimant sustained a compensable hand injury. Thereafter, he injured his shoulder during the course of a job trial as part of his vocational rehabilitation. The insurer denied the shoulder injury claim on the ground that the shoulder injury was a consequence of the hand injury and the claimant had not established that the hand injury was the major contributing cause of the shoulder injury.

The claimant argued that his shoulder injury was compensable because it had occurred in the course of an authorized training program. The court agreed that, under its earlier decision of Wood v. SAIF, 30 Or App 1103 (1977), the claimant would have been correct. However, the court concluded that amended ORS 656.005(7)(a)(A), as interpreted in Hicks v. Spectra Physics, supra, dictated a different result.

The Kephart court reiterated that an injury or condition that is not directly related to an industrial accident is compensable only if the major contributing cause of the injury or accident is the compensable injury. Kephart, supra, 118 Or App at 76 (quoting Hicks v. Spectra Physics, supra, 117 Or App at 297). Because the injury that the claimant had sustained during vocational rehabilitation was not directly related to his earlier compensable industrial accident, and because the compensable injury was not the major contributing cause of the consequential injury, the court concluded that the claimant's consequential condition was not compensable. See id. at 79. In reaching that conclusion, the court recognized the distinction between traveling to and participating in vocational rehabilitation, but did not alter its holding. Id.

In accord with Gasperino, Hicks and Kephart, we must first determine whether claimant's back injury was directly related to his compensable accident or indirectly related to his compensable injury. If it is the former, the material contributing cause standard applies. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, supra. If it is the latter, claimant's back injury is compensable only if his earlier compensable injury is the major contributing cause of his back injury. ORS 656.005(7)(a)(A); Hicks, supra, 117 Or App at 297; Kephart, supra, 118 Or App at 79.

Claimant argues that his back injury is a direct result of his compensable industrial accident.[1]

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[1] Claimant actually asserts that his current low back condition is "a direct consequence to his industrial injury[.]" (Claimant's Appellant's Brief at 2). Because the thrust of claimant's appeal is that ORS 656.005(7)(a)(A) does not apply to this case, we understand claimant actually to be arguing that his current condition is directly related to his original industrial accident. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, supra.

That argument is without merit. The uncontroverted evidence reveals that claimant's back injury occurred while he was participating, albeit somewhat tangentially, in a medical examination regarding his earlier compensable injury. There is no evidence directly linking claimant's compensable accident and his subsequent low back injury. Accordingly, under ORS 656.005(7)(a)(A), claimant's back injury is compensable only if the evidence satisfies the major contributing cause standard. We conclude that it does not.

There is no medical evidence regarding the cause of claimant's low back condition. The only evidence regarding causation consists of the stipulated facts and claimant's written statement regarding the accident at Dr. Fuller's office. (Tr. 2-3; Ex. 15). Even assuming that this case is one that does not require expert medical evidence of causation, see Betty Barnett, 46 Van Natta 9 (1994) (order on remand), we nevertheless conclude that, on this record, the evidence fails to establish that claimant's back injury was caused, in major part, by his earlier compensable injury. Therefore, we conclude that, under ORS 656.005(7)(a)(A), claimant's low back condition is not compensable.

In reaching this conclusion, we acknowledge claimant's argument that this case is distinguishable from Hicks and Kephart because here, he was engaging in activities directed by the employer at the time of the back injury whereas, in both of those cases, the claimants had been engaged in activities that were not controlled by the employers. We are mindful of that distinction. However, we have found nothing in ORS 656.005(7)(a)(A), or the cases interpreting that statute, that manifests the legislature's intent to exclude from ORS 656.005(7)(a)(A)'s coverage those cases in which a worker sustains a consequential injury while engaging in an activity that is directed or controlled by an employer. Accordingly, we adhere to our conclusion that, under ORS 656.005(7)(a)(A), claimant's claim fails.

ORDER

The Referee's order dated August 27, 1993, as corrected on September 2, 1993, is affirmed.

July 21, 1994 Cite as 46 Van Natta 1495 (1994)

In the Matter of the Compensation of
SUSAN E. KRISTICH, Claimant
WCB Case No. 93-10210
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Lipton's order that: (1) awarded temporary disability for the period of claimant's aggravation claim; (2) assessed a penalty for the insurer's allegedly unreasonable failure to pay temporary disability; and (3) awarded 4 percent (12.8 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration had awarded no permanent disability. In her brief, claimant asserts that the Referee improperly admitted evidence. On review, the issues are evidence, temporary disability, penalties, and unscheduled permanent disability. We modify in part and reverse in part.

FINDINGS OF FACT

Claimant has an accepted claim for a right iliolumbar sprain. She also has a preexisting congenital spinal anomaly. A May 1991 Determination Order initially closed the claim and awarded only temporary partial disability. It was affirmed by an Order on Reconsideration. On February 28, 1992, the insurer denied a claim for aggravation.

Claimant requested a hearing, challenging the Order on Reconsideration and aggravation denial. Referee Hoguet rejected claimant's arguments that her claim had been prematurely closed and, alternatively, that she was entitled to permanent disability. However, Referee Hoguet found that claimant had proved that her condition compensably aggravated in July 1991 and set aside the insurer's denial. Finally, Referee Hoguet concluded that claimant had been terminated from her work for reasons unrelated to her compensable injury and that she was not entitled to "interim time loss" or a penalty for the insurer's failure to pay such benefits. Referee Hoguet's order was not appealed.

On April 30, 1993, a Determination Order closed the aggravation claim, awarding no additional temporary or permanent disability. Claimant requested reconsideration and underwent examination by a medical arbiter. The August 1993 Order on Reconsideration affirmed the Determination Order in all respects.

Claimant worked as a waitress between August 1992 and October 1993.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, over claimant's objection, the Referee admitted into evidence Exhibit 56, a letter signed by claimant's treating physician, Dr. Burchiel, indicating that he concurred with the medical arbiter's report. (Tr. 4). The letter was generated in November 1993, subsequent to the issuance of the Order on Reconsideration. On review, claimant renews his objection to the admission of the document.

Where a medical arbiter or panel of arbiters has been appointed by the Director, ORS 656.268(7) operates to prohibit any subsequent medical evidence concerning a worker's impairment from being admitted into the record at hearing. Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993). Therefore, to the extent that Exhibit 56 relates to claimant's permanent impairment, it was not admissible and we do not consider it with regard to that issue. However, finding no basis for limiting its admissibility with regard to any issue except impairment, the Referee properly admitted it for purposes of determining temporary disability.

Temporary Disability

The Referee found that claimant was entitled to temporary disability for the entire period of her aggravation claim. The insurer challenges this conclusion, asserting that Referee Hoguet decided the issue of temporary disability in the prior proceeding and, therefore, claimant is precluded by principles of res judicata from relitigating the matter.

Referee Hoguet, after finding that claimant proved a compensable aggravation, addressed whether claimant was entitled to "interim time loss" and found that she was not entitled to any "interim compensation." Therefore, we agree with the insurer that the issue of temporary disability was litigated during the proceeding before Referee Hoguet.

However, we disagree that Referee Hoguet decided the entire temporary disability issue. Referee Hoguet's order does not specify the period of time he considered in making his determination, referring to the issue in terms of "interim time loss" and "interim compensation." However, because interim time loss normally refers to the period of time between the date of aggravation and denial, we find that his decision was limited to that period between claimant's July 1991 worsening and the insurer's February 28, 1992 aggravation denial.

Consequently, we conclude that Referee Hoguet "actually decided" claimant's entitlement to temporary disability for this period and, thus, claimant is prevented by issue preclusion from relitigating the issue in this proceeding. See North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). However, because the factual transaction in the prior proceeding did not concern claimant's entitlement to temporary disability after February 28, 1992, we further find that neither issue preclusion nor claim preclusion prevents claimant from now litigating that issue. See Drews v. EBI Companies, 310 Or 134, 140 (1990) Thus, we proceed to address this matter.

Shortly before the insurer issued its February 28, 1992 denial, claimant was examined by Dr. Howell, chiropractor, at the insurer's request. Dr. Howell found that the accepted strain condition had resolved and was medically stationary without permanent impairment. (Exs. 30-5, 35-14). With regard to claimant's continued complaints, Dr. Howell indicated that etiology was unknown. (Id.) Dr. Toliver, claimant's then-treating physician, concurred with the report on March 7, 1992. (Ex. 32).

On July 14, 1992, claimant was examined by Dr. Burchiel, neurosurgeon. He found that claimant's condition was "improving dramatically" and indicated that she was in no further need of treatment. (Ex. 38). On January 21, 1993, however, Dr. Burchiel noted "some recurrence of back pain." (Ex. 42).

On July 2, 1993, claimant was examined by medical arbiter Dr. Martens. Although noting that claimant had a congenital right sacroiliac joint abnormality, he found "no chronic and permanent medical condition arising out of the accepted condition[.]" (Ex. 54-4). Dr. Burchiel concurred with the report on November 15, 1993. (Ex. 56).

A claimant's substantive entitlement to temporary disability accrues upon closure and is based on proof of disability due to the compensable claim during the time the claim was open. See SAIF v. Taylor, 126 Or App 658 (1994). Based on this record, we find that claimant's accepted condition had resolved without permanent impairment by the time the insurer issued its February 28, 1992 aggravation denial. The only evidence that claimant continued to be disabled by the accepted condition after this date is the insurer's "Form 2195" dated April 16, 1993 indicating that claimant was released only to "other suitable" work. (Ex. 44). However, there is no indication who filled out the form or upon what information it was based. (Id.) In view of the reports from Dr. Howell and Dr. Martens, both of which were concurred in by the treating physicians, and the fact that claimant performed her regular waitressing work for a substantial period of the time her claim was open, we give the form little weight.

Consequently, finding no persuasive evidence that claimant was disabled due to her compensable injury from February 28, 1992 through the April 30, 1993 claim closure, we conclude that she is not entitled to temporary disability benefits for this period. See SAIF v. Taylor, supra.

Penalties

We further agree with the insurer that it should not be assessed a penalty because it unreasonably failed to pay any temporary disability, as the Referee found. First, because the issue of entitlement to a penalty for the insurer's failure to pay interim compensation was addressed and decided by Referee Hoguet, claimant is precluded from relitigating the issue for the period between July 1991 and February 28, 1992. See North Clackamas School Dist. v. White, supra.

Furthermore, the record contains no verification from the attending physician of an inability to work after February 28, 1992, which would trigger an obligation to pay procedural temporary disability. See SAIF v. Taylor, 126 Or App 658 (1994). As discussed above, claimant failed to prove entitlement to subtantive temporary disability due to her compensable condition after February 28, 1992 through claim closure. Consequently, we find no unreasonable refusal to pay procedural or substantive temporary compensation. See ORS 656.262(10).

Permanent Disability

Finally, the insurer disputes the Referee's conclusion that claimant proved entitlement to 4 percent unscheduled permanent disability. We agree with the insurer that there is no evidence of impairment due to the compensable condition.

First, as discussed above, Dr. Howell found that the accepted strain had resolved without permanent impairment; Dr. Toliver concurred in the report. Dr. Burchiel, after initially noting that claimant's condition had dramatically improved, found that she had recurrence of back pain. However, Dr. Burchiel further provided that increased symptoms were due to "increasing work activities" without indicating that claimant's accepted condition was involved. More importantly, Dr. Burchiel provided no evidence of permanent impairment.

Finally, according to Dr. Martens, claimant exhibited some decreased range of motion. However, in light of his opinion that claimant had "no chronic and permanent medical condition arising out of the accepted condition" while noting a congenital right sacroiliac joint abnormality, we conclude that any impairment was not due to the accepted condition.

Therefore, finding no evidence of permanent impairment due to the accepted condition, we conclude that claimant is not entitled to permanent disability.

ORDER

The Referee's order dated December 9, 1993 is modified in part and reversed in part. That portion of the order admitting Exhibit 56 into evidence is modified to the extent that the document is

not admissible for the purposes of determining permanent impairment. Those portions of the order awarding temporary disability, permanent disability, and a penalty are reversed. The April 30, 1993 Determination Order, as affirmed by the August 12, 1993 Order on Reconsideration, is reinstated and affirmed. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
KEVIN R. LATHROP, Claimant
WCB Case No. 91-03523
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Hall.

Claimant requests review of Referee Emerson's order that: (1) declined to award claimant's counsel an "out-of-compensation" attorney fee; and (2) declined to assess penalties and related attorney fees for the SAIF Corporation's failure to timely pay the "out-of-compensation" fee. On review, the issue is entitlement to an "out-of-compensation" attorney fee.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated October 8, 1993 is affirmed.

Board Member Hall dissenting.

I disagree with the majority's decision declining to require the SAIF Corporation to reimburse claimant's counsel an "out-of-compensation" attorney fee, which SAIF instead paid directly to claimant. Accordingly, I dissent.

The Referee decided this case under Mohammad Zarifi, 42 Van Natta 670 (1990). Zarifi held that, where the Board awards an out-of-compensation attorney fee, claimant's counsel may perfect an enforceable lien against an award of additional compensation (thereby requiring the carrier to pay the fee directly to counsel) if: (1) the claimant has consented to the payment of fees directly to counsel; and (2) the Board authorized the direct payment of fees to counsel. See Id. at 672.[1] Based on the record in the present case, I find that both of those requirements have been satisfied. Therefore, SAIF should be required to reimburse claimant's counsel for the fee erroneously paid directly to claimant.[2]

The attorney fee agreement in this case provides that claimant's counsel "shall be paid in accordance with the rules adopted by the Workers' Compensation Board * * *." (Ex. 2a). It then sets forth the maximum amounts to which counsel is entitled for obtaining various forms of increased compensation for claimant. (Id.) On its face, the fee agreement manifests claimant's consent to the direct payment of an out-of-compensation fee to his counsel.

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[1] The Zarifi holding is based on former OAR 438-47-010(5), which provided, in part, that a fee allowed under that division was a lien on compensation, and former OAR 438-47-080, which provided that the Board could, with the claimant's consent, order payment of a fee awarded from permanent disability directly to the claimant's attorney. Both of those rules have been repealed, WCB Admin. Ord. 1987-5, and apparently replaced by OAR 438-15-010(2), (3) and OAR 438-15-085(1), respectively. OAR 438-15-085(1) provides:

> "If the claimant consents in the attorney fee agreement, the referee or the Board may order the payment of approved attorney fees directly to the claimant's attorney in a lump sum when the fee is to be paid out of an award of compensation for permanent disability. The lump sum shall not be due until the award of compensation becomes final."

[2] It is not necessary, for purposes of this dissent, to discuss the real and/or theoretical problems associated with collecting the fee from claimant. See Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994) (Board Members Hall and Gunn, dissenting).

This record also satisfies the second element of the Zarifi test. The subject stipulation[3] states, in part, that "[c]laimant's counsel shall receive 25 percent of the additional permanent partial disability awarded at next closure, amount not to exceed $2,800.00" (Ex. 4-2; emphasis added). That stipulation, including the fee provision, was approved by a Board referee.

For these reasons, I conclude that SAIF was legally obligated to pay the out-of-compensation attorney fee set forth in the subject stipulation directly to claimant's counsel. Because SAIF violated the terms of the stipulation by paying the entire amount of compensation then due directly to claimant, I would require SAIF to reimburse claimant's counsel now.

This result comports with Nancy E. O'Neal, 45 Van Natta 2081 (1993). In that case, this Board held: where there is additional compensation due while a matter is pending before the Board (or its Hearings Division) and the carrier thereafter pays all the additional compensation to the claimant, the carrier may be required to reimburse the fee to claimant's counsel if: (a) the carrier knew that claimant was represented by counsel when it paid out the entire award to the claimant; and (b) claimant's counsel could have taken no further action to prevent the direct payment to the claimant. Id. at 2082.

Here, on the day on which SAIF paid the out-of-compensation fee directly to claimant, SAIF knew full well that claimant was represented by this attorney. Indeed, they had just finalized the subject negotiated stipulation. (Ex. 4). The only question is whether claimant's counsel could have taken further action to prevent the direct payment of the fee to claimant. On this record, I would conclude that the answer to that question is "no." Claimant's counsel bargained for a stipulation that required SAIF to pay the out-of-compensation fee directly to claimant's counsel. On this record, both prongs of the O'Neal holding have been met. Again, SAIF should now be required to pay counsel the fee that it mistakenly paid to claimant.

For the foregoing reasons, I respectfully dissent.

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[3] There are two stipulated orders in the record. (Exs. 4, 7). Exhibit 4 is at issue here.

In the Matter of the Compensation of
BARBARA D. PACHECO, Claimant
WCB Case No. 93-01609
ORDER ON REVIEW
Johnson, Cram & Associates, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of that portion of Referee Black's order that set aside the employer's denial of claimant's occupational disease claim for a mental condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception. We do not adopt the last sentence in the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

In order to establish compensability of a stress-related mental condition, the worker must prove that the employment conditions were the major contributing cause of the disease and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must

be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d). Claimant has the burden of proof to establish the compensability of her occupational disease. ORS 656.266.

The Referee found that claimant had established all of the required elements of a compensable mental stress claim. Therefore, he concluded that claimant's mental condition, diagnosed as an adjustment reaction with mixed features, was compensable. The employer contends that the Referee erred in determining that: (1) the employment conditions were the major contributing cause of the mental condition; and (2) the work conditions are not generally inherent in every working situation. We agree with the employer's latter contention.

We adopt the Referee's reasoning and conclusions regarding his determination that the employment conditions (participating in a training program) were the major contributing cause of the mental condition. However, we disagree with the Referee's determination that those employment conditions are not generally inherent in every working situation.

Here, claimant had worked in the payroll department of the employer, US West Communications, for about eight years at the time her payroll job began to be phased out because the employer was transferring the payroll functions to its Denver office. The employer was also planning on implementing a new system for assigning telephone lines, the FACS system. Implementation of this system required retraining of all depack workers and line assigners. (Tr. 41, 66-67). Both of those jobs involved the assignment of telephone lines. However, the line assigner job was more highly skilled because it dealt with commercial customers.

Following a transition period when claimant was working part-time in the payroll department and training part-time for a depack job, claimant worked about one year full-time as a depack worker. On June 1, 1992, claimant began the FACS training program, along with a group of her co-workers. She felt overwhelmed by this training program and complained to the instructor. The employer offered to transfer her into other positions that would pay her the same wage but would not entitle her to the pay increase that would result from completion of the FACS training program. (Tr. 29, 78-79). Claimant turned down this offer based on the lack of a pay increase. (Tr. 29). Following a period of time off work, during which she received psychological counseling regarding coping skills, claimant returned to work and successfully completed the FACS training program.

The Referee reasoned that claimant was subjected to "overwhelming" change rather than "incremental or gradual" change. He concluded that this type of overwhelming change was not generally inherent in every working situation.

The employer argues that the question is whether the general situation claimant faced was generally inherent in every working situation. The employer characterizes this situation as being one where the employer was attempting to keep up with technological developments by implementing a new system that the affected employees were required to learn. The employer notes that it provided the necessary training regarding this new system and claimant's symptoms developed in the context of that training. We agree with the employer's analysis.

In Barry M. Bronson, 44 Van Natta 1427 (1992), the law had changed to ban the sale of polystyrene products, which adversely affected the claimant's sales. Relying on Housing Authority of Portland v. Zimmerly, 108 Or App 596 (1991), the Board found it inappropriate to focus on the specifics of the ban itself and overlook its general relationship to the workplace. Applying that concept, the Board concluded that operating within everchanging legal parameters is a condition generally inherent every work place. See also Mary A. Murphy, 45 Van Natta 2238 (1993).

As with legal parameters, technology is also everchanging, and operating within everchanging technological parameters can be a condition generally inherent in every work place. It is the manner in which an employer handles technological changes that determines whether the situation is a condition generally inherent in every work place. For example, an employer who makes technological changes without providing the worker with reasonable training to handle those changes can create a condition that is not generally inherent in every work place. On the other hand, if reasonable training is provided to implement technological changes, that situation can be a condition that is generally inherent in every work place.

We find that the present case comes within the latter category. Here, the employer provided a training program for its employees, including claimant, in order to implement technological changes. Furthermore, we find nothing unreasonable or improper in the employer's training program.

Claimant argues that a lack of proper training is a condition not generally inherent in every working situation. Therefore, claimant contends that, because she did not have an adequate technological background, the FACS training program was not adequate for her. Claimant relies on Joy Burke, 43 Van Natta 1237 (1991), in support of her argument.[1]

We find claimant's reliance on Joy Burke, supra, to be misplaced. In Burke, the claimant was transferred to a supervisory position without any supervisory training. The Board found that such conditions were not generally inherent in every working situation. However, here, claimant was not required to perform a job for which she was not properly trained. Instead, the employer provided a training program to implement technological changes and to prepare claimant and her co-workers for those changes. It was this training program that caused claimant stress.

Claimant argues that she was not initially able to handle the training program. However, she has not shown anything unreasonable about the training program offered by the employer. Therefore, on this record, we find that claimant was faced with a condition that is generally inherent in every work place, i.e., an employer-provided training program for the purpose of implementing technological changes. Because claimant has failed to establish that the employment conditions which caused her mental disorder were conditions not generally inherent in every working situation, the claim is not compensable.

ORDER

The Referee's order dated August 12, 1993 is reversed in part and affirmed in part. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

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[1] Claimant also relies on James A. Morgan, 43 Van Natta 2450 (1991), in support of her argument. We find that reliance misplaced. The language claimant relies on in James A. Morgan, supra, to support her contention that the focus should be on whether her training was inadequate deals with whether the claimant had proven that his alleged insufficient training was a "real and objective" stressor, not whether inadequate training was a condition not generally inherent in every working situation. Here, there is no dispute that the FACS training program was a real and objective stressor for claimant.

In the Matter of the Compensation of
CHARLES E. TRENTO, Claimant
Own Motion No. 66-0290M
OWN MOTION ORDER
Coons, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

The SAIF Corporation submitted claimant's request for medical services for his July 26, 1965 compensable low back injury. SAIF recommended that the Board deny the provision of the proposed surgery (facet joint rhizotomies bilaterally at L4-5 and L5-S1) based on its contention that the treatment is not reasonable and necessary.

On January 25, 1994, the Board issued an own motion order referring this case to the Hearings Division for a fact finding hearing on the issue of whether the proposed rhizotomies are appropriate treatment for claimant's compensable injury. Following the fact finding hearing, the assigned Referee was instructed to make a recommendation to the Board, based on findings of fact made as a result of the hearing, as to whether the Board should order the claim reopened under its own motion jurisdiction.

The fact finding hearing was held before Referee Spangler on April 6, 1994. At the fact finding hearing, claimant's attorney requested an assessed fee for his services in setting aside SAIF's alleged "de facto" denial. On April 29, 1994, Referee Spangler issued a recommendation that the Board reopen claimant's claim under its own motion jurisdiction for the proposed rhizotomy surgery. Referee Spangler also denied claimant's attorney's request for an assessed fee.

Following receipt of Referee Spangler's recommendation, the Board established a briefing schedule to allow the parties an opportunity to respond to the recommendation. The parties' responses have been received. Claimant's attorney renews his request for an assessed fee, or, in the alternative, an out-of-compensation fee. The issues are: (1) appropriateness of the proposed surgery; and (2) attorney fees.

FINDINGS OF FACT

We adopt the findings of fact set forth in the Referee's recommendation, with the following supplementation.

By Own Motion Order dated February 12, 1993, the Board authorized SAIF to reopen claimant's July 26, 1965 low back injury claim to provide medical services. Those medical services consisted of surgical decompression of the spinal canal stenosis at L3-4. That is a separate surgery from the proposed rhizotomy surgery, which is the subject of the current litigation.

The February 12, 1993 Own Motion Order also authorized payment of temporary total disability compensation beginning the date claimant was hospitalized for the surgical decompression procedure. SAIF was ordered to close the claim pursuant to OAR 438-12-055 when claimant was medically stationary. That claim remained opened at the time that authorization was requested for the proposed rhizotomy surgery, which is the subject of the current litigation.

CONCLUSIONS OF LAW AND OPINION

Reasonableness and Necessity of the Proposed Rhizotomy Surgery

We adopt as our reasoning and conclusions on this issue the Referee's reasoning and conclusions as set forth in his recommendation to the Board, with the following supplementation.

Because claimant's industrial injury occurred prior to January 1, 1966, ORS 656.245, which provides lifetime medical services for compensable injuries, does not apply to that injury. However, the Board has own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. In addition, we may authorize the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. See ORS 656.278(1)(b).

We find the requested rhizotomy surgery reasonable and necessary and find that the anticipated relief it will provide from severe, ongoing pain, constitutes special circumstances justifying the surgery. OAR 438-12-037(1)(f). Accordingly, we authorize the provision of these medical services.

In addition, we note that claimant's July 26, 1965 low back injury claim remains open pursuant to the Board's February 12, 1993 Own Motion Order, which authorized the claim to be reopened for an earlier decompression surgery. Claimant's claim was in open status at the time that authorization was requested for the currently proposed rhizotomy surgery. Therefore, it is not necessary to reopen the claim to authorize payment of temporary disability compensation.

However, we note that, if claimant is not currently receiving temporary disability compensation as a result of the earlier surgery, he is entitled to temporary total disability compensation beginning the date he is hospitalized for the rhizotomy surgery. ORS 656.278(1)(a). When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

Attorney Fees

At the fact finding hearing, claimant's attorney argued that, if his efforts at the hearing resulted in obtaining the proposed surgery for claimant, he should receive an insurer-paid fee pursuant to ORS 656.386(1) for prevailing over SAIF's "de facto" denial. The Referee found that, given the Board's exclusive jurisdiction over own motion matters, he could not finally decide whether SAIF's own motion recommendation constituted a denial or whether claimant had "finally prevailed" entitling his attorney to an assessed fee. Therefore, the Referee concluded that, at that time, claimant's attorney was not entitled to an assessed fee under ORS 656.386(1).

Claimant's attorney requests that the Board award him an assessed fee for his legal services at the fact finding hearing and on this own motion matter. Claimant's attorney notes that he participated in the fact finding hearing and solicited medical reports from claimant's physicians.

We do not doubt the value of claimant's attorney's services in establishing that the proposed surgery is appropriate treatment for claimant's compensable condition. However, entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 628 (1984).

In Gwen A. Jackson, 46 Van Natta 357 (1994), on recon 46 Van Natta 822 (1994), the Board determined that a claimant was entitled to an attorney fee award under ORS 656.386(1) for finally prevailing against an order or decision denying a medical services claim. We identified the critical inquiry as whether the carrier's conduct constitutes a decision denying the claimant's claim for compensation. See Daniel K. Bevier, 46 Van Natta 41 (1994), on recon 46 Van Natta 909 (1994).

Thus, the issue presented here is whether SAIF's action in recommending that the proposed rhizotomy surgery be disallowed for this pre-1966 injury claim constitutes a decision denying the claimant's claim for compensation. We conclude that it does not.

Claimant's aggravation rights expired on his July 26, 1965 low back injury claim. Therefore, this claim is within the Board's own motion jurisdiction. ORS 656.278(1); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). In addition, inasmuch as claimant was injured prior to January 1, 1966, he does not have a lifetime right to medical services for his compensable low back injury.[1] Instead, the Board in its own motion authority has sole jurisdiction over claimant's medical services claims for his pre-1966 injury. ORS 656.278(1)(b); Carl M. Price, 46 Van Natta 514 (1994); Carl M. Price, 44 Van Natta 978 (1992); Roy Hansen, 43 Van Natta 990 (1991).

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[1] But note that workers who were injured within the period from August 5, 1959, through December 31, 1965, and whose injuries resulted in permanent total disability, are entitled to medical services related to their compensable injuries without petitioning for own motion relief. See Or Laws 1959, ch 589, 2. Although claimant was injured within this time period, his injury did not result in permanent total disability. Therefore, this exception does not apply to claimant and his medical services claim is within the Board's own motion jurisdiction.

Thus, in order to obtain medical services for his pre-1966 injury, claimant's sole remedy is to petition the Board for own motion relief. ORS 656.278(1)(b). This petition process is initially handled by the carrier in that the carrier must process any claim for additional compensation for a worsened condition filed after the expiration of a claimant's aggravation rights as a request for own motion relief. OAR 438-12-020. In doing so, the carrier is required to notify claimant and the Board in writing whether it recommends that the claim be "reopened" or "denied." OAR 438-12-025(2); 438-12-030.

Here, claimant's claim was already in open status due to an earlier surgery that the Board had authorized. However, any additional medical services beyond those already authorized by the Board also had to be authorized by the Board. ORS 656.278(1)(b); OAR 438-12-037(1).

SAIF properly forwarded claimant's request for the proposed rhizotomy surgery to the Board. SAIF recommended that this proposed treatment be disallowed based on its contention that this treatment was not of proven efficacy. However, that recommendation was just that: a recommendation. Because the Board has exclusive jurisdiction over medical service requests relating to claimant's pre-1966 injury, SAIF has no authority to deny such a medical services claim. See Raymond Thornsberry, 44 Van Natta 1206 (1992) (Because claimant was not entitled to medical services without Board authorization, the carrier did not have to formally deny an unrelated condition). Therefore, SAIF's recommendation did not constitute a denial, "de facto" or otherwise. Accordingly, there was no decision denying the claimant's claim for compensation. Thus, there is no basis for an assessed attorney fee pursuant to ORS 656.386(1). Gwen A. Jackson, supra; Daniel K. Bevier, supra.

In the alternative, claimant's attorney requests an out-of-compensation fee. Claimant's attorney notes that his retainer agreement with claimant limits any out-of-compensation attorney fee to $1,050. However, claimant's attorney argues that a fee of $2,000 would be more reasonable, given the fact that a fact finding hearing was held and he solicited reports from two of claimant's treating physicians.

Here, it is likely that the authorized rhizotomy surgery will result in increased temporary disability compensation. If that is the case, pursuant to OAR 438-15-080, claimant's attorney would be entitled to an out-of-compensation attorney fee. However, although claimant's attorney references a retainer agreement, he did not submit a copy of that agreement to the Board. We cannot approve an attorney fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved. However, if claimant promptly submits an executed retainer agreement, we are prepared to reconsider this order (provided that our reconsideration occurs within 30 days of this order). In any event, we currently decline to address claimant's attorney's argument that he should be awarded an out-of-compensation fee greater than that agreed to in the retainer agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLINTON C. BUZZARD, Claimant
WCB Case No. 93-02257
SECOND ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

On June 29, 1994, we issued an Order on Reconsideration which reduced the attorney fee awarded in our May 12, 1994 Order on Review from $5,000 to $4,000. Additionally, in our Order on Reconsideration, we stated that, because claimant may require surgery for a disc herniation, he may potentially receive temporary and permanent disability benefits.

The self-insured employer requested reconsideration of our June 29 order, noting that claimant is subject to the Board's Own Motion jurisdiction. The employer further noted that our reference to claimant's potential right to receive permanent disability appeared to be in error. We agree.

Pursuant to ORS 656.278, when a claim is reopened under the Board's Own Motion jurisdiction, a claimant may be entitled to further temporary disability benefits, but not permanent disability benefits. Accordingly, as modified herein, we republish our June 29, 1994 Order on Reconsideration. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANE S. CLINARD, Claimant
WCB Case No. 93-04988
ORDER ON REVIEW
Nancy F. A. Chapman, Claimant Attorney
Myers & Radler, Defense Attorneys

Reviewed by Board Members Westerband, Neidig, and Gunn.

Claimant requests review of those portions of Referee Neal's order that: (1) upheld the self-insured employer's denial of her cystocele/bladder condition; (2) declined to assess a penalty or related attorney fee for an allegedly unreasonable discovery violation. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant had not established that her cystocele condition was compensable. We agree based on the following reasoning.

When disability or need for treatment is due to the combination of an injury and a preexisting condition, the injury is compensable only if it is the major contributing cause of the disability or need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod, 120 Or App 590 (1993). After reviewing the medical opinions, we are not persuaded that claimant has satisfied her requisite burden of proof.

Dr. Petty, claimant's treating surgeon, signed a concurrence letter indicating that the March 1993 lifting incident was the major contributing cause of claimant's cystocele condition and need for treatment. Dr. Petty also indicated that claimant's weakened pelvic wall "predisposed" her to the occurrence of the cystocele condition. (Ex. 15). Dr Broms, who treated claimant one time, also signed a concurrence letter indicating that the work incident was the major cause of claimant's cystocele condition. (Ex. 14). However, in his chartnotes, Dr. Broms reported that the cystocele condition may have occurred prior to the work incident. (Ex. 21).

Dr. Allen, who performed an independent medical examination, agreed that the work incident contributed to claimant's cystocele condition, but reported that other factors also contributed. (Ex. 9). Specifically, Dr. Allen opined that claimant's vaginal wall weakness was a preexisting condition which also contributed to her cystocele condition and need for treatment. (Id.). Dr. Rudoff, who performed a records review, opined that claimant's work activities combined with her preexisting pelvic support disorder to cause claimant's recurrent cystocele and need for treatment. (Ex. 18, 19). While Dr. Rudoff acknowledged that claimant's work activities may have aggravated the underlying condition, the major cause of her condition and need for treatment was the preexisting pelvic support disorder. (Id.).

Generally, we rely on the opinion of the treating physician, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to rely on Dr.

Petty's opinion. Dr. Petty offers no explanation for his conclusion that the work incident was the major contributing cause of claimant's cystocele condition. Moreover, although Dr. Petty acknowledges that claimant has pelvic wall weakness, he does not address the causal aspect of this condition other than to say it predisposed claimant to the cystocele condition. Dr. Broms' opinion also lacks explanation and is further weakened by his chartnotes which indicate that the cystocele condition may have occurred prior to the work incident.

By contrast, both Dr. Allen and Dr. Rudoff address the contribution of claimant's preexisting pelvic support disorder and the work incident and persuasively explain their reasoning for the conclusions reached. Considering the less than persuasive opinions of Drs. Petty and Broms in light of the contrary opinions from Drs. Allen and Rudoff, we conclude that claimant has not established that the work incident was the major contributing cause of her cystocele condition or need for treatment. Consequently, claimant's condition is not compensable.

Penalties

We adopt the conclusions and reasoning concerning the penalty issue as set forth in the Referee's order.

ORDER

The Referee's order dated July 28, 1993 is affirmed.

Board Member Gunn dissenting.

The majority concludes that claimant did not establish that her cystocele condition is compensable. Because I believe the majority misinterprets the medical evidence, I dissent.

All the physicians in the record attribute claimant's cystocele (prolapsed bladder) to a variety of factors including weight, childbirth, previous surgeries and work activities. In addition, the medical opinions are in agreement that claimant's weight, prior pregnancies, and surgeries contributed to claimant having a pelvic support disorder. The problem is that claimant is not seeking treatment or compensation for a pelvic support disorder. Rather, her claim is for a prolapsed bladder.

The majority treats claimant's pelvic support disorder as a "preexisting condition" for purposes of applying ORS 656.005(7)(a)(B). I disagree. Claimant's pelvic support disorder is, as Dr. Petty described, a predisposition. As such, it may have made claimant more susceptible to sustaining a prolapsed bladder, but it did not cause the prolapsed bladder or need for treatment. Claimant's work activities did. I do not believe a predisposition or susceptibility should be considered a "preexisting condition" under ORS 656.005(7)(a)(B). See Preston v. Wonder Bread, 96 Or App 613 (1989); Tucker v. Liberty Mutual Insurance, 87 Or App 607 (1987). Moreover, even if the pelvic support disorder is considered a preexisting condition, the only evidence that it combined with claimant's injury is a statement in a letter written by the employer's counsel which Dr. Rudoff "checked the box." I do not find this persuasive evidence, particularly since Dr. Rudoff never even examined claimant.

On this record it is clear that the lifting incident caused claimant to seek treatment. The fact that she may have been more susceptible to sustaining a prolapsed bladder (by virtue of her pelvic support disorder) does not change that fact. Accordingly, I believe that claimant's condition is compensable. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
FRANK E. DIEU, Claimant
WCB Case Nos. 91-00117 & 91-00116
ORDER ON REMAND
Karen M. Werner, Claimant Attorney
Bottini, et al., Defense Attorneys
Janelle Irving (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to its June 14, 1994 order, the court has reversed our prior order, Frank E. Dieu, 44 Van Natta 1712 (1992), which found the SAIF Corporation responsible for claimant's low back condition. Citing SAIF v. Drews, 318 Or 1 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his back in 1967 while working for McDonald Candy Company (McDonald). That injury resulted in at least three surgeries, including spinal fusions from L4 to S2. The claim was closed in 1971 with a total of 35 percent unscheduled permanent disability.

In February 1990, while working for SAIF's insured, claimant slipped, striking his shoulder and arm on a wall, and falling in the direction of some stairs. He immediately experienced a warm sensation in his back and legs.

Finding that claimant's original 1967 injury with McDonald was the major contributing cause of his current low back condition, the Referee concluded that responsibility for claimant's condition remained with McDonald. McDonald requested Board review.

On review, we reversed the Referee's order. Citing our order in Rosalie Drews, 44 Van Natta 1091 (1992), we held that McDonald had the burden of proving that claimant's injury with SAIF's insured had materially contributed to claimant's disability and need for treatment. Finding that McDonald had met its burden, we concluded that responsibility shifted to SAIF.

SAIF petitioned for review to the Court of Appeals. Citing the Supreme Court's opinion in SAIF v. Drews, supra, the court has reversed our order and remanded for reconsideration.

Interpreting ORS 656.005(7)(a), the Court in Drews reached the following conclusions. "Compensable injury" encompasses an application of the limitation criteria found in ORS 656.005(7)(a)(B). In other words, if the accidental injury described in paragraph (a) combines with a preexisting condition, to be compensable, the injury must be "the major contributing cause of the disability or need for treatment" under subparagraph (B). The Court reasoned that such a determination is made regardless of whether the preexisting condition was compensable.

Turning to ORS 656.308(1), the Court concluded that if the accidental injury was found not to be "the major contributing cause" under ORS 656.005(7)(a)(B), claimant would not have sustained a "new compensable injury involving the same condition" as described in ORS 656.308(1). Consequently, the Court determined that the first employer would remain responsible. Conversely, if the accidental injury was the "major contributing cause," the Court held that responsibility would shift to the subsequent employer because claimant would have sustained a "new compensable injury involving the same condition." SAIF v. Drews, supra.

Thus, on remand, to establish a "new compensable injury" under ORS 656.308, McDonald must prove that the February 1, 1990 incident with SAIF's insured was the "major contributing cause" of claimant's disability and need for medical treatment. We conclude that claimant has not met that burden.

The medical evidence is uncontroverted that claimant's 1967 injury with McDonald was the major contributing cause of his need for the January 1991 surgery. (Exs. 59, 64, 66). We are particularly persuaded by the opinion of Dr. Lewis, who performed the 1991 surgery. See Argonaut Ins. Co. v.

Mageske, 93 Or App 698 (1988). Dr. Lewis stated that, although the February 1990 slip and fall injury did contribute to the present need for surgery, the major contributing cause was claimant's initial injury in 1967. (Ex. 59). Accordingly, we affirm the Referee's opinion that McDonald remains responsible for claimant's low back condition.

The Referee further found SAIF's denial of compensability unreasonable in light of the fact that there was no evidence that claimant's current low back condition was not work-related. On review, we continue to find SAIF's denial unreasonable.

SAIF's compensability denial resulted in a delay of payment of compensation by preventing the designation of a paying agent pursuant to ORS 656.307. (Ex. 60). In SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983), the court upheld assessment of a penalty against a nonresponsible carrier for its unreasonable denial of compensability. Furthermore, the court rejected the carrier's argument that, even if a penalty could be assessed, there were no "amounts then due" from the nonresponsible carrier.

Relying on the court's decision in Moyer, we have found that a penalty may be assessed against a nonresponsible carrier when its unreasonable denial of compensability delays payment of compensation by preventing the designation of a paying agent. Michael L. Whitney, 45 Van Natta 446 (1993); Michael P. Yauger, 45 Van Natta 419 (1993); Steven R. Helms, 45 Van Natta 330 (1993). This penalty may be based on the "amounts then due" from the responsible carrier. Accordingly, we assess a penalty, payable by SAIF, of 25 percent of the amounts "then due" by McDonald at the time of hearing as a result of the Referee's order.

Finally, although finding McDonald responsible for claimant's current condition, the Referee nevertheless awarded a $1,900 attorney fee, payable by SAIF. Citing Karen J. Bates, 39 Van Natta 42 (1987), aff'd SAIF v. Bates, 94 Or App 666 (1989), the Referee reasoned that SAIF's compensability denial placed claimant's entitlement to benefits in jeopardy. On remand, we affirm the Referee's attorney fee award, to be paid by SAIF.

However, because McDonald requested Board review, and we have found that claimant's compensation should not be reduced or disallowed, McDonald is responsible for the $560 attorney fee award granted by our prior order. Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

Accordingly, on remand, the Referee's order dated June 7, 1991 is affirmed. As supplemented and modified herein, that portion of our August 28, 1992 order that granted a $560 attorney fee award is republished, except that the fee shall be paid by McDonald.

IT IS SO ORDERED.

In the Matter of the Compensation of
GORDON P. KIGHT, Claimant
WCB Case No. 91-09579
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Claimant requests reconsideration of our June 30, 1994 Order on Remand that reversed a referee's order that: (1) continued the hearing to allow claimant to depose his treating physician; and (2) set aside the self-insured employer's denial of claimant's occupational disease claim for his low back condition. After reviewing claimant's request and supporting memorandum, we continue to adhere to our prior conclusion. However, we offer the following response to claimant's arguments in support of reconsideration.

As stated in our Order on Remand, this matter was before the Board on remand from the Court of Appeals. Georgia-Pacific Corporation v. Kight, 126 Or App 244 (1994). In the Order on Review in this matter, we had adopted and affirmed a referee's decision to continue the hearing to allow claimant to depose Dr. Bert, treating physician. Reasoning that we had abused our discretion in upholding the continuance without first making findings of extraordinary circumstances under OAR 438-06-091(4) and 438-06-081, the court remanded for reconsideration. Kight, supra, 126 Or App at 248.

On remand from the court, we rejected claimant's request to have the case remanded to the referee, and concluded that claimant had failed to show that extraordinary circumstances existed sufficient to warrant a continuance of the hearing pursuant to OAR 438-06-081(2) or (4). Particularly, we concluded that claimant had failed to establish that Dr. Bert was unavailable because he had failed to comply with a subpoena, or that completion of the record could not have been accomplished with due diligence.

In his request for reconsideration, claimant asserts that the Board should interpret the above-mentioned rules to require only that claimant show that it was practically, not virtually, impossible to subpoena Dr. Bert to testify at hearing. We need not address that assertion, as we were directed by the court to make a finding regarding whether "extraordinary circumstances" existed under OAR 438-06-081. Kight, supra, 126 Or App at 248. As the court noted, "the Board's rules expressly provide that the unavailability of a witness is not an 'extraordinary circumstance,' unless the witness has failed to appear after having been duly subpoenaed." (126 Or App at 246). (Emphasis supplied). Having no room to maneuver, we found, on remand, no evidence of extraordinary circumstances. Accordingly, we reversed the referee's decision to continue the hearing for Dr. Bert's deposition. We continue to adhere to that conclusion on reconsideration.[1]

In so holding, we are mindful that on the facts of this case, the result we have reached can be described as "harsh." Indeed, on initial review, the Board approved the Referee's decision granting the continuance. Perhaps a rule amendment is in order. However, until such amendment, the Board is bound by the express language of the rule.

Accordingly, our June 30, 1994 order is withdrawn. On reconsideration, we adhere to and republish our June 30, 1994 order in its entirety, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Along with his request for reconsideration, claimant submits his counsel's affidavit, which outlines additional facts surrounding counsel's efforts to procure Dr. Bert's testimony. We treat the submission as a motion for remand to the referee. See ORS 656.295(5); Elizabeth S. Fields, 45 Van Natta 301 (1993). We have not considered the affidavit, because claimant has failed to establish (claimant does not assert) that the evidence contained in the affidavit was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988).

In the Matter of the Compensation of
ORVILE L. LYONS, Claimant
WCB Case Nos. 92-08435 & 93-01420
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband and Neidig.

The SAIF Corporation requests review of that portion of Referee Baker's order which set aside its partial denial of claimant's current low back condition and need for surgery. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact but also offer the following brief summary of the relevant facts.

Claimant sustained a prior compensable low back injury on April 24, 1972, while employed by the SAIF insured employer, C.L. Scoggin. During the ensuing years, diagnostic studies identified degenerative osteoarthritis in claimant's lumbar spine. Claimant eventually underwent a lumbar laminectomy at L4-5 in 1979, which a Referee determined was causally related to the 1972 injury.

Claimant did quite well after the surgery, experiencing only occasional soreness and requiring no medical treatment until he sustained an additional low back injury on April 5, 1988, while employed as a log truck driver for Carpenter Trucking, also insured by SAIF.

Ever since this 1988 injury, claimant experienced symptoms in the low back, but he did not seek medical treatment from September 1988 to October 1990, when he came under the care of an orthopedic surgeon, Dr. Kitchel, for ongoing low back and right leg pain. Numerous diagnostic studies were subsequently undertaken which revealed extensive degenerative disease in the lumbar spine, as well as spinal stenosis. Dr. Kitchel referred claimant to a neurosurgeon, Dr. McGirr, who identified L-5 radiculitis as the cause of claimant's symptoms in June 1991. In early 1992, Dr. McGirr recommended decompression of the L-5 nerve root.

In March 1992, Dr. Kitchel formally requested that SAIF provide authorization for low back surgery. SAIF arranged an examination with Drs. Duff and Brooks, who concluded that the major contributing cause of the need for surgery was the degenerative disease in the lumbar spine. When SAIF received concurrences from Drs. Kitchel and McGirr, it denied aggravation of the 1988 injury and the compensability of claimant's current low back condition on May 29, 1992. On November 25, 1992, SAIF denied claimant's current low back condition and need for treatment under the 1972 claim.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's degenerative back condition was a compensable portion of the 1972 claim. Reasoning that the major contributing cause requirement of ORS 656.005(7)(a)(B) only applied to preexisting noncompensable conditions, the Referee held that claimant's current low back condition and need for surgery need only be materially related to claimant's compensable 1988 low back injury. Further reasoning that the 1988 injury had rendered the preexisting and underlying degenerative condition symptomatic and had brought about claimant's need for surgery, the Referee concluded that the 1988 injury was a material contributing factor in claimant's need for surgery. Accordingly, the Referee set aside SAIF's denial under the 1988 claim of claimant's current low back condition and need for surgery.

On review, SAIF contends that the major contributing cause standard of ORS 656.005(7)(a)(B) is applicable, citing SAIF v. Drews, 318 Or 1 (1993). It also asserts that the medical evidence does not establish that the 1988 injury is the major contributing cause of claimant's need for surgery.

We agree that the major contributing cause standard is applicable, regardless of whether claimant's preexisting degenerative condition is compensable or noncompensable. SAIF v. Drews, supra. However, we still find that claimant has sustained his burden of proving that his current low back condition and need for treatment are compensable.

In U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), the claimant had a cervical strain superimposed on a preexisting degenerative cervical spine disease. While the medical evidence indicated that claimant's cervical strain had not caused or worsened the degenerative condition itself, it did establish that the cervical strain had rendered the degenerative condition symptomatic, resulting in a need for surgery. The court concluded that this was sufficient to make the claimant's surgery compensable. 120 Or App at 358.

The circumstances of this claim are similar. Dr. Kitchel diagnosed a lumbar strain superimposed on a preexisting degenerative disease. (Ex. 71-20). Claimant was essentially asymptomatic for eight years, until the 1988 injury rendered his degenerative condition symptomatic. The current issue is whether claimant's compensable 1988 injury is and remains the major contributing cause of his need for surgery. See ORS 656.005(7)(a)(B).

The medical evidence is not a model of consistency. Dr. Kitchel initially concluded in April 1991 that claimant's need for medical treatment was related to the 1988 injury, because the injury had made the preexisting degenerative condition symptomatic. (Ex. 46). Subsequently, however, Dr. Kitchel identified the degenerative condition as the major contributing cause of claimant's need for treatment. (Exs. 64, 70). Dr. Kitchel was deposed in order to clarify his opinion.

While Dr. Kitchel testified that the degenerative condition was the major contributing factor in claimant's need for surgery, he also confirmed that claimant's need for treatment in April 1991 was related to claimant's compensable lumbar strain and the symptomatic degenerative lumbar spine disease. (Ex. 71-21). Dr. Kitchel also testified that he was recommending surgery because of the symptoms of the degenerative condition, which the compensable 1988 injury had rendered symptomatic. (Ex. 71-24). Although Dr. Kitchel continued to insist that the major contributing cause of claimant's need for surgery was the degenerative condition (Ex. 71-34), we consider his opinion sufficient to establish that claimant's 1988 lumbar strain made his preexisting lumbar degenerative disease symptomatic, resulting in a need for surgery. This is all that is necessary under Burtis, supra, for claimant's surgery to be compensable.

We find additional support for our conclusion elsewhere in the record. Dr. McGirr initially agreed that claimant's preexisting degenerative condition was the major contributing cause of claimant's need for surgery. (Ex. 65). However, in a more detailed medical report, Dr. McGirr opined that claimant suffers from right L-5 radiculitis caused in "greater part" by the April 5, 1988 injury. (Ex. 68). Dr. McGirr confirmed that the recommended surgery was necessary to decompress or relieve pressure on the nerve root rendered symptomatic by the 1988 injury. (Ex. 68). Thus, Dr. McGirr's opinion provides additional support for our conclusion that the 1988 injury remains the major contributing cause of claimant's need for treatment under ORS 656.005(7)(a)(B).

The remaining medical opinions are from Drs. Duff and Brooks, the examining physicians, and Dr. Strukel, an orthopedic surgeon who conducted an internal records review for SAIF. As previously noted, Drs. Duff and Brooks concluded that the major contributing cause of claimant's need for medical treatment is the noncompensable degenerative condition. (Ex. 62). We do not find this opinion very persuasive because it contains little reasoning and, most importantly, it does not address the effect of claimant's long asymptomatic period on the causation issue. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Kenneth E. Rickard, 46 Van Natta 126 (1994).

Dr. Strukel's medical report is more detailed and more thoroughly reasoned. Dr. Strukel also opined that the degenerative condition was the major contributing cause of claimant's need for surgery. (Ex. 69). While, according to Dr. Strukel, claimant's 1988 injury did not worsen the degenerative condition, he does concede that the injury may have brought the symptoms of the degenerative condition to claimant's attention. (Ex. 69-5). In this sense his opinion is consistent with those of Drs. Kitchel and McGirr because he appears to acknowledge that the 1988 injury rendered the preexisting degenerative condition symptomatic. Again, we emphasize that a symptomatic worsening is all that is necessary under ORS 656.005(7)(a)(B), provided that the compensable injury remains the major contributing cause of the need for medical treatment. U-Haul of Oregon v. Burtis, supra.

In conclusion, when viewed in its totality, we find the medical evidence establishes that claimant's compensable 1988 lumbar strain is and remains the major contributing cause of claimant's need for surgery. Therefore, claimant's "resultant condition" under ORS 656.005(7)(a)(B) is compensable. Thus, we affirm the Referee's holding that claimant's current low back condition and need for treatment are compensable.

Since claimant has prevailed over SAIF's appeal, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering all the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's attorney's services on review is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have considered the time devoted to this case (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 6, 1993 is affirmed. Claimant's attorney is awarded an assessed attorney fee of $1,000 for services on review, payable by SAIF.

Board Member Neidig dissenting.

Inasmuch as I believe the majority has misanalyzed this dispute, I must respectfully dissent.

As noted by the majority, since claimant's 1988 compensable cervical strain injury combined with his preexisting degenerative condition, his "resultant condition" is compensable if his compensable injury is and remains the major contributing cause of his need for medical treatment and disability. ORS 656.005(7)(a)(B). Relying on U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), the majority reasons that claimant has satisfied this statutory prerequisite because his compensable injury prompted his preexisting asymptomatic degenerative condition to become symptomatic. I disagree with the majority's reasoning and conclusion.

First, since it is undisputed that claimant experienced symptoms from his preexisting degenerative condition prior to his 1988 compensable injury, I am unable to agree that his preexisting condition was asymptomatic. Consequently, I believe that the majority errs in applying the Burtis holding to this fact situation.

Secondly, in reasoning that ORS 656.005(7)(a)(B) is satisfied merely with a showing that a compensable injury increases the symptomatology of a preexisting condition, the majority is misconstruing the statute. ORS 656.005(7)(a)(B) expressly provides that a "resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." (Emphasis added.)

Where, as here, a claimant has not only experienced symptoms but has received medical treatment for a preexisting degenerative condition prior to suffering a compensable injury, compensability of the "resultant condition" is established only when the compensable injury is the major contributing cause of the entire "resultant condition" and not merely increased symptoms from the preexisting condition. In doing otherwise, the majority reads the word "condition" right out of the statute in that it finds claimant's surgery claim to be compensable under ORS 656.005(7)(a)(B) based solely on a symptomatic flare-up of a preexisting symptomatic condition.

Thirdly, even if Burtis is applicable to the present dispute, claimant has not established the compensability of his current surgery claim. In finding support for its conclusion, the majority emphasizes Dr. Kitchel's statement that the surgery was required to address symptoms of the degenerative condition which were triggered by the 1988 compensable injury. Yet, as acknowledged by the majority, Dr. Kitchel has expressly concluded that the major contributing cause of claimant's surgery was the preexisting degenerative condition.

Such a conclusion does not satisfy the requisite standard set forth in ORS 656.005(7)(a)(B) as interpreted by Burtis. Moreover, this conclusion is shared by nearly every examining physician who offered an opinion regarding the relationship between claimant's compensable injury and his surgery claim. By focusing on the symptomatic flare-up of a preexisting noncompensable condition as the triggering event for the need for surgery, the majority not only misinterprets the medical opinions but it also fails to properly apply ORS 656.005(7)(a)(B).

In conclusion, every worker who suffers from a preexisting condition who eventually experiences symptoms and seeks treatment will do so because of the onset of those complaints. In other words, if the worker is not hurting, there are no symptoms from the preexisting condition to treat. If the eventual triggering event for those symptoms from a preexisting noncompensable condition is an industrial accident, the sole reason for the ensuing treatment is generally the accident which prompted those increased symptoms. Yet, the ultimate source for those symptoms is the preexisting noncompensable condition.

Accordingly, in the absence of persuasive medical evidence establishing that the major contributing cause of the "resultant condition" (as opposed to the symptomatic flare-up of the preexisting condition) is the compensable injury, a claim under ORS 656.005(7)(a)(B) must fail. Inasmuch as this case presents one of those claims, I must respectfully dissent.

In the Matter of the Compensation of
JAMES W. NICHOLLS, Claimant
WCB Case No. 91-01349
SECOND ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Tooze, Shenker, et al., Defense Attorneys

On June 23, 1994, we withdrew our May 24, 1994 Order on Remand, which had affirmed a Referee's order which upheld the insurer's denials of claimant's chiropractic treatments. We took this action to consider claimant's contention that his counsel remained entitled to the $1,000 attorney fee granted by our October 15, 1992 reconsideration order for establishing a causal relationship between the compensable injury and the disputed chiropractic treatments. Having received the insurer's response, we proceed with our reconsideration.

In our October 15, 1992 reconsideration order, we held that we lacked authority to resolve the issues of whether the disputed chiropractic treatments were approved by an "attending physician" and whether the treatments were palliative or curative. However, reasoning that we were authorized to determine whether the disputed chiropractic treatments were causally related to claimant's injury, we answered that question in the affirmative. Finding that claimant was entitled to an attorney fee award for prevailing over the insurer's denial of a causal relationship, we awarded claimant's attorney a $1,000 fee.

As noted in our May 24, 1994 remand order, the court reversed our decision. Concluding that we are authorized to resolve this treatment dispute, the court remanded for reconsideration. Following our reconsideration, we found that the disputed treatments are not subject to reimbursement. Consequently, we affirmed the Referee's order which had upheld the insurer's denials.

Claimant does not contest that portion of our decision which found that the treatments were not reimbursable. Instead, he asserts that he remains entitled to the $1,000 attorney fee granted by our October 15, 1992 reconsideration order. We disagree.

As previously discussed, the attorney fee awarded by our prior reconsideration order was based on the premise that our authority to consider the insurer's denial was solely limited to examining the causal relationship between claimant's compensable injury and the disputed chiropractic treatments. In reversing our decision and remanding for reconsideration, the court has ruled that we are authorized to resolve this entire dispute.

In other words, our jurisdiction extends over the entire denial issued by the insurer. If a claimant establishes that disputed medical services are causally related to a compensable injury, but does not prove that the services are appropriate and reimbursable, the claimant has not finally prevailed over a denial of compensation. See Anthony J. Colistro, 43 Van Natta 1835 (1991); Arbra Williams, 43 Van Natta 142, 144 (1991). Under such circumstances, the claimant is not entitled to an attorney fee award under ORS 656.386(1).

Here, claimant has established that the disputed chiropractic treatments were causally related to his compensable injury. Nevertheless, he has not proven that the treatments are reimbursable. Since the insurer's denials were based on both grounds, claimant has not finally prevailed over these denials of compensation. Therefore, his counsel is not entitled to an attorney fee award under ORS 656.386(1).

Accordingly, on reconsideration, as supplemented and modified herein, we republish our May 24, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS G. REED, Claimant
WCB Case No. 93-09207
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband, and Hall.

Claimant requests review of Referee Black's order that found that claimant was not entitled to additional temporary disability benefits prior to January 27, 1992. On review, the issue is temporary disability.

The Board adopts and affirms the order of the Referee, with the following supplementation.

On review, claimant argues that a December 11, 1992 stipulation does not bar him from asserting entitlement to underpaid temporary disability benefits prior to January 27, 1992. Specifically, claimant contends that the issue could not have been raised at the time of the parties' stipulation as he was not paid until after the stipulation was approved. We disagree.

A July 21, 1992 Order on Reconsideration awarded temporary disability benefits for various time periods between September 16, 1991 through March 27, 1992. The self-insured employer requested a hearing regarding an issue of temporary disability benefits from the period of January 1992 through April 1992. The parties subsequently sought referee approval of a stipulation which specifically addressed the temporary disability dispute. The parties' stipulation also provided that:

> "...this Stipulation resolves all issues which were raised or which could have been raised on or before the date this settlement is approved by a referee including, but not limited to, issues of processing, issues arising from the April 13, 1992 Notice of Closure, and issues arising from the July 21, 1992 Order on Reconsideration."

Here, the parties' stipulation specifically resolved all issues involving the Order on Reconsideration and processing issues. We conclude that the issue of an alleged underpayment of temporary disability benefits for the period prior to January 27, 1992, is an issue which necessarily involves both the reconsideration order and processing. Claimant knew or reasonably should have known of the alleged underpayment at the time of negotiations for the stipulation. Specifically, the underpayments allegedly occurred before January 27, 1992. The stipulation was entered almost 12 months later.

Consequently, because such issues were resolved by the stipulation, we agree with the Referee that claimant is precluded from further litigating that issue. See Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993); Charles J. Hawkes, 46 Van Natta 1060 (1994) (Where the parties' stipulation provided that all issues and claims raised and raisable were being settled and the claimant's low back condition was an issue that could have been raised prior to the stipulation, the claimant's subsequent low back claim was barred by the stipulated settlement).

ORDER

The Referee's order dated December 2, 1993 is affirmed.

Board Member Hall dissenting.

I do not agree with the majority's interpretation of the parties' stipulation; therefore, I must respectfully dissent. The stipulation provides:

> "The parties agree that pending the outcome of the appeal of the April 22, 1992 Opinion and Order the employer will not pay temporary disability from January 27 to April 12, 1992. At the conclusion of the appellate process, if the employer prevails it will not pay temporary disability to the claimant from January 27 through April 12, 1992. On the

other hand, if at the conclusion of the appellate process the claimant remains entitled to some periods of temporary disability, the employer will pay those periods, but not beyond the medically stationary date of March 27, 1992. Any such payment will be made less unemployment insurance benefits which the claimant has received during that period and the payment will not be due until the claimant advises the employer and its claim servicing agent of the amount of those benefits."

The stipulation further provides that all issues raised or raisable are resolved, other than those specifically set forth therein. As quoted above, claimant's entitlement to "some periods of temporary disability" up to the stipulated stationary date of March 27, 1992 is "specifically set forth."

Consequently, if the Seney case relied upon by the majority is applicable at all, it should be applied to preclude the employer from re-litigating an issue of entitlement to benefits. In other words, the employer in this case agreed in the stipulation to pay all temporary disability benefits to which claimant is entitled (limited only by the cutoff/medically stationary date of March 27, 1992). Therefore, by characterizing this as a processing issue, the employer actually is seeking to relitigate claimant's entitlement to temporary disability benefits. Because, as the majority notes, this stipulation settled all matters raised or raisable, Seney bars the employer from relitigating this issue concerning claimant's temporary disability benefits.

In the Matter of the Compensation of
MARK A. ROSENBLOOM, Claimant
WCB Case No. 92-08790
SECOND ORDER ON RECONSIDERATION
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

The insurer requests reconsideration of our June 23, 1994 Order on Reconsideration in which (clarifying our May 26, 1994 order) we: (1) concluded that claimant's original accepted consequential psychological condition (adjustment disorder) had not worsened; and (2) found (affirming the Referee) that claimant has established a second compensable consequential psychological condition (obsessive/compulsive disorder). Specifically, the insurer views the Board's distinction between claimant's preexisting anxiety disorder and consequential obsessive/compulsive disorder as presenting the insurer with an impossible claims processing situation. Having considered the insurer's motion and supporting memoranda, we proceed with our reconsideration.

As a preliminary matter, the insurer argues that any claim for misclassification of claimant's obsessive/compulsive disorder must be processed as an aggravation claim. The insurer contends that because claimant's aggravation rights expired May 20, 1992, any aggravation claim for an obsessive/compulsive disorder must be processed as an Own Motion claim. See ORS 656.273(4)(b); ORS 656.277(2).

On February 12, 1986, the insurer accepted claimant's February 18, 1985 injury claim. The claim was closed by Determination Order on May 20, 1987. Thereafter, on September 13, 1990, the insurer accepted claimant's adjustment disorder as a consequence of the February 1985 injury. On May 14, 1992, claimant made a further claim for an additional psychological condition. In November 1992, the insurer denied that claimant's psychological condition for which he has received medical treatment since April 1992 (obsessive/compulsive disorder) is compensably related to the 1985 injury. The Referee found that claimant has established a second compensable consequential psychological condition, diagnosed as an obsessive/compulsive disorder. We affirmed.

The insurer has never accepted claimant's obsessive/compulsive disorder. Claimant has never requested that any obsessive/compulsive disorder claim be reclassified nor has claimant filed an aggravation claim for an obsessive/compulsive disorder. The insurer's citation to reclassification/aggravation/Own Motion law has no relevance to claimant's claim for a second compensable consequential psychological condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Primarily, the insurer disagrees with the Board's decision (in our May 26, 1994 order) to accord little weight to the opinion of examining psychiatrist Parvaresh on the issue of claimant's obsessive/compulsive disorder, and urges the Board to reconsider the evidence. In that order, we found that, although Dr. Parvaresh reexamined claimant in June 1992, and observed that claimant was overly engrossed with various body functions, Dr. Parvaresh ascribed claimant's current psychological problems to his preexisting anxiety disorder, without addressing the opinions of Dr. Farley (claimant's current treating psychiatrist) and Dr. Larsen (claimant's former treating psychiatrist), that claimant's physical injury caused his obsessive/compulsive condition. Moreover, we found that Dr. Parvaresh did not discuss the effects of claimant's obsession with health and fitness on his current mental functioning.

The insurer argues that Dr. Parvaresh was clearly aware of claimant's obsessive/compulsive disorder, but analyzed it as a part of claimant's underlying makeup. Therefore, the insurer contends that the Board misconstrued Dr. Parvaresh's lack of discussion of claimant's obsessive/compulsive disorder. Having considered the insurer's arguments and reviewed the record, we continue to find the opinions of Drs. Farley and Larsen persuasive, for the reasons expressed in our May 26, 1994 order. Accordingly, we continue to conclude that claimant has established that the 1985 injury is the major contributing cause of his current psychological condition (obsessive/compulsive disorder) and need for treatment. Therefore, the carrier shall process this claim pursuant to law.

Finally, the insurer argues that claimant's physicians are not going to provide opinions that will permit it to meaningfully process this claim to closure, but will instead continue to treat claimant until his noncompensable anxiety disorder is also treated and resolved. We find the insurer's concerns speculative.

Accordingly, we grant the insurer's motion. On reconsideration, as supplemented herein, we adhere to and republish our May 26, 1994 order and June 23, 1994 Order on Reconsideration. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARCHIE M. ULBRICH, Claimant
WCB Case No. TP-94002
THIRD PARTY DISTRIBUTION ORDER
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Aetna Casualty & Surety Company (Aetna) has petitioned the Board to resolve a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, Aetna contends that claimant is not entitled to interest accrued ($4,981.37) on that portion of its lien designated for payment of future benefits. We hold that claimant is entitled to the accrued interest.

FINDINGS OF FACT

In June 1986, claimant sustained a compensable injury when he fell into a 12 foot hole with 60 pounds of equipment. His injury was diagnosed as a fracture of the right foot with compression fractures of his L1-L2 discs. As a result of the compensable injury, claimant underwent five surgical procedures on his right foot and developed severe arthritis. Claimant suffered compensable arterial fibrillations following three of the five surgeries. In addition, claimant developed left shoulder tendinitis and torn left rotator cuff due to his use of crutches. Claimant also sustained a psychiatric disorder as a consequence of the compensable injury.

Claimant has not returned to work since the compensable injury and his claim remains in open status.

In 1988, claimant commenced a civil action against a third party defendant. In 1989, the case was tried before a jury which returned a verdict for claimant in excess of $600,000. Thereafter, the third party appealed the verdict. In July 1991, during the pendency of the appeal, claimant and the third party entered into a settlement agreement whereby claimant received the sum of $600,000. The settlement was approved by Aetna.

In a September 10, 1991 letter, Aetna's counsel informed claimant's counsel that Aetna considered its third party lien satisfied by the payment from claimant's counsel of $259,172.76. The letter also noted that, of that amount, $192,752.48 had been paid directly to Aetna. The remainder, $66,420.28, was to be held in an interest bearing account by Aetna's counsel. Claimant and Aetna agreed that the principal amount ($66,420.28) would be disbursed to Aetna when Aetna's ongoing cost of compensation reached or exceeded that amount. Finally, the letter indicated that claimant and Aetna had not yet resolved the distribution of the interest accruing in the account.

To date, Aetna's claim costs associated with this claim have exceeded $259,172.76, the amount which it agreed satisfied its lien. Unable to settle the "interest" dispute, the parties have submitted the question for Board resolution.

CONCLUSIONS OF LAW

If the worker or beneficiaries settle a third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(1); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory formula for distribution of a third party recovery obtained by judgment is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Thereafter, the worker shall receive at least 33 1/3 percent of the balance of the recovery. ORS

656.593(1)(b). After those deductions, the paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under the workers' compensation law. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d); Liberty Northwest Ins. Corp. v. Golden, 116 Or App 64, 67-68 (1992).

When either a worker or the paying agency, in the course of negotiating a third party settlement, makes a representation to the other which could affect the other's position on the amount of the settlement, the other is entitled to rely on that representation. Williams, supra at p. 620. We applied this principle in Timothy J. Gheen, 43 Van Natta 1484 (1991).

In Gheen, the claimant agreed to honor a paying agency's $18,000 lien in return for the agency's approval of a third party settlement. Following the settlement, the claimant objected to a portion of the agency's lien which apparently pertained to a projected pain center program. Reasoning that the paying agency was entitled to rely on claimant's representation that its lien would be honored, we declined to alter the parties' mutually agreed "just and proper" distribution. See also Robert L. Hardt, 45 Van Natta 1487 (1993) (Paying agency entitled to rely on claimant's representation that its lien, consisting of CDA proceeds, would be honored when such representation was made in exchange for the paying agency's approval of a third party settlement).

Here, Aetna contends that, since its claims costs have exceeded $259,172.76, it is entitled to the accrued interest. However, pursuant to Aetna's counsel's September 10, 1991 letter, Aetna agreed that the payment of $259,172.76 from claimant to Aetna's counsel totally satisfied Aetna's third party lien, including the present value of expected future expenditures. As of that point, Aetna's lien had been specifically quantified and it agreed it was not entitled to any further amounts. Consequently, the actual claim costs that have accrued since the agreement are of little relevance to the current dispute.

ORS 656.593(1)(c) provides that a paying agency is entitled to retain the balance of the third party recovery to the extent of its actual compensation expenses plus the present value of its reasonably to be expected future claims costs. Thus, upon approval of the third party settlement and resolution of its actual/projected lien, Aetna could have asserted its immediate receipt of the entire $259, 172.76. However, Aetna agreed that it was only entitled to $192,752.48 at that time. Moreover, the parties further agreed that an amount consistent with the remainder of Aetna's lien, $66,420.28, would be placed in an interest bearing account and would not be distributed to Aetna until its actual costs reached or exceeded that amount. Thus, the parties expressly agreed that those monies would not be immediately transferred to Aetna.

Since it was agreed that the remaining balance of Aetna's lien was not to be distributed to Aetna until its actual costs reached or exceeded that amount, it follows that Aetna's right to the monies would not attach until that event occurred. Inasmuch as Aetna had no right to the funds until the triggering event, it follows that Aetna would not be entitled to interest that accrued on those funds prior to the "condition precedent," i.e., when Aetna's actual costs reached $66,420.28.

Had the remaining $66,420.28 been immediately distributed to Aetna at the time of its approval of the third party settlement and the resolution of its lien any interest on that amount would certainly belong to Aetna. However, Aetna agreed that it was not entitled to those monies until its future claims expenses satisfied that $66,420.28 balance. Were we to conclude that Aetna was entitled to the accrued interest, we would not only be reaching a decision inconsistent with the "conditional nature" of the parties arrangement, but we would effectively be concluding that Aetna's lien exceeded the amount to which the parties agreed at the time of the third party settlement. Such a conclusion would be inconsistent with the rationale expressed in the Williams, Gheen, and Hardt holdings. We are not prepared to reach such a conclusion.

Inasmuch as Aetna agreed that $259,172.76 fully satisfied its present and future lien and since Aetna was not entitled to the remaining $66,420.28 until its subsequent claims costs reached that figure, we hold that claimant is entitled to the interest accrued ($4,981.37). Therefore, Aetna's counsel is directed to forward to claimant the aforementioned monies from counsel's trust account.

IT IS SO ORDERED.

In the Matter of the Compensation of
AGAFIA H. BORU, Claimant
WCB Case Nos. 93-06857, 93-05449 & 93-03425
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys
Raymond Myers (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 6, 1994 Order on Review that adopted and affirmed with comment a Referee's order setting aside its denial of claimant's aggravation claim for a neck, shoulder, right arm, and upper back condition. Specifically, SAIF takes exception to our statement of clarification that it was not the assignment to modified work in 1992, but rather the loss of modified work in March 1993, "that established claimant's loss of earning ability and constituted a worsening of her compensable condition." SAIF contends that the quoted statement "without a recitation of the Referee's opinion, could well lead a reader to conclude that the Board does not even require medical evidence of worsening--that a mere termination of modified work is sufficient to establish an aggravation." After reviewing SAIF's motion and supporting memorandum, and claimant's response to SAIF's motion, we continue to adhere to our prior conclusion. However, we offer the following supplementation to our previous decision.

We do not share SAIF's concern. The Referee recited that, in order to establish a compensable aggravation claim, claimant must prove, by medical evidence supported by objective findings, that the injury-related condition has worsened since the last arrangement of compensation, that claimant must show that the worsened condition resulted in diminished earning capacity below the level fixed at the time of the last award or arrangement of compensation, and that the diminished earning capacity must be in excess of that contemplated by the last arrangement of compensation.

The Referee then analyzed the evidence and concluded that claimant's accepted conditions worsened, that her current disability and need for treatment are supported by objective findings, and that claimant suffered diminished earning capacity as a result of her worsened condition.

On review, we adopted and affirmed the Referee's opinion, with the clarification noted. By adopting and affirming the Referee's reasoning and conclusions in our prior order, the Board adopted the proper legal standard for establishing a compensable aggravation claim. Under these circumstances, we are confident that no reader will conclude that the Board does not require medical evidence of worsening in order to establish an aggravation.

Primarily, SAIF urges the Board to reconsider the evidence and find that there is insufficient evidence that, as a result of a worsening of claimant's original injury, claimant became less able to work. In the alternative, SAIF urges the Board to recite what evidence supports a worsening and what evidence supports a loss of earning capacity due to that worsening.

On reconsideration, we continue to find that claimant has suffered diminished earning capacity as a result of her worsened condition. Moreover, as the Referee's order thoroughly analyzed the evidence in light of the applicable law, we decline to reanalyze the evidence on reconsideration.

Based on the reasoning expressed above, as well as for the reasons expressed in the Referee's decision and our prior order, we find that claimant has satisfied the statutory requirements for establishing a compensable aggravation claim.

Claimant is entitled to an additional assessed attorney fee for her counsel's services on reconsideration. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services concerning SAIF's request for reconsideration is $300, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response to SAIF's request for reconsideration), the complexity of the issues, and the value of the interest involved.

Accordingly, our July 6, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 6, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WARREN R. FRIEND, Claimant
WCB Case No. 93-06646
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Nichols' order that: (1) dismissed as untimely claimant's request for hearing from a Notice of Closure; (2) found that the insurer had properly processed claimant's April 9, 1992 back injury claim; and (3) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are jurisdiction (timeliness), claim processing, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

Claimant's April 9, 1992 back injury claim was closed by a July 30, 1992 Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction (Timeliness)

We adopt the Referee's opinion on this issue, with the following comments.

We agree with the Referee that claimant's May 6, 1993 request for hearing contesting the July 30, 1992 Notice of Closure was untimely. We also agree that the 180 day time period for requesting a hearing was tolled from January 8, 1993 (when claimant requested reconsideration) until March 4, 1993 (when the initial Order on Reconsideration issued). Thus, the time for requesting a hearing expired on March 22, 1993. Claimant requested a hearing on May 6, 1993. Therefore, the request was untimely.

Alternatively, even if the March 4, 1993 reconsideration order was ineffective (because claimant did not receive it), reconsideration was "deemed" denied 75 days after the request for reconsideration. See ORS 656.268(6)(b); OAR 436-30-050(23). Thus, under this scenario, the Appellate Review Unit (ARU) lost jurisdiction over the matter on March 24, 1993.

The 180 day period for requesting a hearing was tolled for 75 days, from the January 8, 1993 request for reconsideration until March 24, 1993. Moreover, because ARU lost jurisdiction when reconsideration was deemed denied under the statute (on March 24, 1993), the ARU's April 29, 1993 abatement order and its purported republication of the March 4, 1993 order are "a nullity." See Sheridan v. Johnson Creek Market, 127 Or App 259 (1994) (When a reconsideration order became final under ORS 656.268(6)(b), the Appellate Review Unit lacked authority to withdraw or amend its prior order and its attempt to do so was "a nullity"). Thus, claimant's May 6, 1993 request for hearing was untimely, even if the March 4, 1993 Order on Reconsideration was ineffective.

Claim Processing

Claimant contends that, because the insurer accepted only a claim for a low back condition, it effectively "de facto" denied a claim for thoracic problems. Relying on a prior stipulation (in which the insurer rescinded its denial of claimant's back injury claim, accepted a low back strain and resolved all issues raised or raisable between the parties), the Referee found that claimant was precluded from litigating the alleged "de facto" denial because he had agreed by stipulation that his condition was a lumbosacral strain. Alternatively, the Referee concluded that there was no "de facto" denial of a thoracic condition

We agree with the Referee that there was no "de facto" denial of a thoracic condition. Our review of the record reveals that claimant has only one back condition, which is in the lower middle back. The diagnoses of lumbosacral strain and thoracic strain have been used interchangeably in referring to this condition. Inasmuch as claimant has only one condition in his back, it, therefore, follows that there could not have been a "de facto" denial of a separate, unaccepted condition.

Moreover, claimant signed a stipulation in which his condition was referred to as a low back strain, based on the last medical report prior to the insurer's acceptance of a lumbar strain. (Ex. 8). All compensation, including medical benefits, was paid to claimant after his claim was accepted. There has been no denial of a thoracic condition. Under these circumstances, we agree with the Referee that the insurer has properly processed the claim.

Alternatively, we would also find that claimant was precluded by the stipulation from litigating a "de facto" denial. On May 8, 1992, the insurer denied claimant's claim for an April 9, 1992 back injury. Claimant requested a hearing. On August 7, 1992, a prior referee approved the parties' stipulation which dismissed claimant's hearing request. In consideration for the insurer's rescission of its denial and payment of additional time loss, claimant stipulated that he was medically stationary and released to his regular work without impairment. In addition, the agreement provided: "It is further stipulated and agreed that this settlement shall resolve all issues that were raised or could have been raised as of the date of approval of this settlement[.]" (Ex. 12).

Assuming for the sake of argument that claimant did have separate lumbar and thoracic conditions (which he did not), the compensability of the thoracic condition could have been raised and negotiated at the time of the stipulation. Under these circumstances, the above-quoted terms of the parties' agreement would preclude claimant from raising issues associated with an injury-related thoracic condition now. See Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994); John P. Robinson, 46 Van Natta 738 (1994).

Finally, because we find no evidence of amounts due or unreasonable resistance to the payment of compensation, claimant is not entitled to penalties or attorney fees. See ORS 656.262(10), 656.382(1).

ORDER

The Referee's order dated September 16, 1993 is affirmed.

July 25, 1994 Cite as 46 Van Natta 1521 (1994)

In the Matter of the Compensation of
MICHAEL J. SALDI, Claimant
WCB Case Nos. 93-00181 & 92-14128
ORDER OF ABATEMENT
Black, Chapman, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Claimant requests abatement and reconsideration of our June 24, 1994 Order on Review which upheld the self-insured employer's denial of claimant's current neck condition. Specifically, claimant contends that given our finding that claimant was credible, we erred in our evaluation of the medical evidence.

In order to allow us sufficient time to consider claimant's motion, we withdraw our June 24, 1994 order. The self-insured employer may submit a response to the motion within 14 days from the date of this order. Thereafter, we shall proceed with our review of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD E. HARP, Claimant
WCB Case No. 93-09574
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee Menashe's order that: (1) ruled to exclude evidence offered by claimant after the record was closed; and (2) upheld the SAIF Corporation's denial of claimant's right wrist condition and surgery. On review, the issues are evidence and compensability.

We adopt and affirm the Referee's order with the following supplementation.

After the record closed, claimant's attorney submitted a report from claimant's treating surgeon, Dr. Buehler. The Referee upheld SAIF's objection to admission of the document on the basis that claimant did not explain why the report could not have been produced at hearing and it did not provide any new information. On review, claimant challenges the ruling, asserting that the document was not available at hearing because Dr. Buehler was on vacation.

The Referee may reopen the record and reconsider his or her decision before a request for review is filed in part based on "the discovery of new material evidence." OAR 438-07-025(1). Such a motion must state the "nature of the new evidence" and explain why the evidence could not reasonably have been discovered and produced at hearing. OAR 438-07-025(2). We review a Referee's ruling under this provision for abuse of discretion. E.g., Mark G. Smith, 43 Van Natta 315 (1991).

At hearing, claimant's attorney stated that Dr. Buehler was on vacation on that date. (Tr. 5). Although that explanation provides why Dr. Buehler could not have generated the report at the time of hearing, it does not explain why the report reasonably could not have been produced before hearing. In particular, we note that claimant first saw Dr. Buehler on July 15, 1993; he filed his request for hearing on August 11, 1993. There was discussion at hearing that Dr. Buehler had provided other reports to claimant's attorney before hearing, (Tr. 4-7), indicating that, between the filing of the request for hearing and the November 8, 1993 hearing, Dr. Buehler was available and could provide an opinion.

Consequently, we agree with the Referee that any opinion provided by Dr. Buehler in the submitted report reasonably could have been produced by the date of the hearing. We find no abuse of discretion with his ruling to exclude the report. OAR 438-07-025(2).

We are unsure of the basis for claimant's assertions on review regarding compensability; however, claimant apparently contends that Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992), is applicable to this case. In Spurgeon, the court held that a claimant's susceptibility or predisposition to a disease, as opposed to causes, is not considered in determining compensability. 109 Or App at 569.

Here, the medical evidence shows that claimant's need for treatment was due to the combination of a compensable wrist sprain with a preexisting scapholunate dissociation. (Exs. 6, 18, 21, 26). Therefore, we agree with the Referee's application of ORS 656.005(7)(a)(B) to analyze compensability. Tektronix, Inc. v. Nazari, 117 Or App 409, on recon 120 Or App 590 (1993) (providing that ORS 656.005(7)(a)(B) is applicable when a compensable injury combines with a preexisting noncompensable condition to cause or prolong disability or the need for treatment). Nothing in the medical evidence indicates that claimant has a susceptibility or predisposition to a disease; rather, the record shows that the wrist sprain and scapholunate dissociation were causes of claimant's need for treatment. Thus, we find no basis for applying Spurgeon.

Relying on Barnett v. SAIF, 122 Or App 279 (1993), claimant further argues that medical evidence is not necessary to prove causation because this case is not complex. In Barnett, the court held that expert medical opinion was not necessary to prove causation because it was not a complex case. In determining whether a case was complex, the court relied on the factors enumerated in Uris v. Compensation Department, 247 Or 420, 426 (1967). 122 Or App at 283.

Applying those factors, we find this case to be complex. In particular, as discussed above, the medical evidence shows that claimant's scapholunate dissociation preexisted the injury and contributed to claimant's symptoms. Furthermore, although claimant testified to the contrary, there was some indication that he had experienced right wrist symptoms before the industrial accident. (Ex. 6-1). Therefore, we conclude that expert medical evidence is necessary for claimant to carry his burden of proof. Barnett v. SAIF, supra.

We agree with, and have adopted, the Referee's order finding that, based on the medical evidence, claimant did not prove compensability of his scapholunate dissociation and need for surgery under ORS 656.005(7)(a)(B).

ORDER

The Referee's order dated December 3, 1993 is affirmed.

In the Matter of the Compensation of
CORENE B. MAYS, Claimant
WCB Case No. 93-08263
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Dennis L. Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Holtan's order that upheld a Director's Order which dismissed her request for vocational assistance because claimant's aggravation rights had expired. On review, the issue is vocational assistance.

We adopt and affirm the Referee's order with the following supplementation.

Claimant concedes that the Court's decision in Harsh v. Harsco Corporation, 123 Or App 383 (1993), rev den 318 Or 661 (1994), likely controls the outcome of this case. However, claimant cites the Board's decision in David F. Meissner, 45 Van Natta 249 (1993), as support for her position that she is entitled to vocational assistance.

Subsequent to the Referee's order, the court reversed our decision in Meissner. All American Air Freight v. Meissner, 129 Or App 104 (1994). The court reversed per curiam citing Harsh v. Harsco Corporation, 123 Or App 383 (1993), rev den 318 Or 661 (1994), which held that "the only benefits available to a claimant whose aggravation rights have expired are those referred to in ORS 656.278(1)." 123 Or App at 387. Finding no statutory authority for vocational benefits for "Own Motion" claimants, the court upheld the Director's order effectively denying such benefits. Id.

We are constrained to follow the court's holding in Harsh and Meissner. Accordingly, because claimant's claim is in Own Motion status, she is ineligible for vocational assistance.

ORDER

The Referee's order dated November 22, 1993 is affirmed.

In the Matter of the Compensation of
KEITH W. MILES, JR., Claimant
WCB Case No. 90-13770
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Pamela A. Schultz, Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of those portions of Referee Spangler's order that: (1) upheld the insurer's denial of claimant's consequential psychological condition; (2) affirmed a Determination Order which awarded 26 percent (83.2 degrees) scheduled permanent disability and 30 percent (45 degrees) unscheduled permanent disability; and (3) authorized the insurer to offset $7,340.37 in overpaid temporary disability against a $3,162.34 award of scheduled permanent disability which was previously awarded, but not paid. The insurer cross-requests review, contending that the Referee erred in concluding that claimant's total awards to date in the claim are 48 percent scheduled permanent disability for his left leg and 26 percent unscheduled permanent disability for his back. On review, the issues are compensability, extent of unscheduled permanent disability and offset.

We adopt and affirm the Referee's order with the following supplementation and clarification concerning the offset and extent of permanent disability issues.

Claimant compensably injured his left leg in September 1987. The claim was first closed in August 1988 by a Determination Order which awarded temporary disability only. That order was subsequently modified by a November 1988 Determination Order which awarded 18 percent scheduled permanent disability for the left foot. In January 1989, the claim was reopened for surgery. The claim was reclosed by a Determination Order dated May 16, 1990, which awarded an additional 12 percent scheduled permanent disability. However, that order was set aside by a May 21, 1990 Determination Order which reduced the period of temporary disability and awarded an additional 30 percent scheduled permanent disability for the left leg and 26 percent unscheduled permanent disability. After ordering the insurer to pay $13,945, the order stated: "This is the value allowed by this order only and does not include payments previously ordered."

In June 1990, the insurer wrote to claimant and explained that it would not pay the entire permanent disability award ordered by the May 21, 1990 Determination Order. In the letter, the insurer concluded that the amount it was ordered to pay by the May 21, 1990 Determination Order was incorrect. The insurer's letter stated that claimant's previous award for the left foot (awarded by the November 1988 Determination Order) should have been deducted since the May 21, 1990 Determination Order award was actually "in lieu of the previous award." The insurer subsequently paid all but $3,162.34 of the May 21, 1990 Determination Order award. (The insurer paid $7,748.53 of the award and offset $3,034.13 in overpaid temporary disability against the remainder of the award, leaving the balance of the award, $3,162.34, still unpaid).

In September 1990, claimant enrolled in an Authorized Training Program (ATP). As a consequence of the training program, claimant's claim was reopened. A November 1990 Determination Order issued which corrected the May 21, 1990 Determination Order. On July 2, 1990, claimant filed a request for hearing raising the issues of penalties and attorney fees and "failure to pay within 30 days of May 21, 1990 Determination Order." On August 9, 1990, claimant filed an amended request for hearing raising the additional issues of temporary total disability and aggravation. On November 9, 1990, claimant filed a second amended request for hearing raising the additional issue of unauthorized set off of permanent disability.

By order dated November 21, 1990, claimant's request for hearing was deferred pending completion of his ATP. After completion of his ATP, claimant's claim was closed by a July 14, 1992 Determination Order. On July 29, 1992, claimant wrote the Board and requested that his case be removed from deferred status and scheduled for hearing. In the same letter, claimant indicated that he was appealing the July 14, 1992 Determination Order. Prior to hearing, claimant raised the additional issues of premature closure, improper claims processing, a November 12, 1992 denial of depression and penalties and attorney fees.

The insurer overpaid claimant $7,340.37 in temporary disability between August 1990 and March 1992. In August 1992, claimant became employed full time.

The Referee found that claimant had timely appealed the May 1990 Determination Orders, but did not timely appeal the November 14, 1990 Determination Order which had become final by operation of law. The Referee further found that claimant had not established entitlement to an additional award of permanent disability. The Referee ordered the insurer to pay the unpaid balance of the $13,945 awarded by the May 21, 1990 Determination Order. In addition, the Referee assessed a penalty against the insurer for unreasonably refusing to pay the full amount of compensation awarded by the Determination Order. However, the Referee also authorized the insurer to offset its $7,340.37 overpayment of temporary disability against the still unpaid balance of $3,162.34 awarded by the May 21, 1990 Determination Order.

Issue on Cross-Appeal

We first address the insurer's argument on cross-appeal. The insurer requests that we modify the Referee's order to reflect that claimant's total award to date is 30 percent scheduled permanent disability for his left leg and 26 percent unscheduled permanent disability for his back, rather than 48 percent scheduled (64.8 degrees) for the left leg, and 26 percent (83.2 degrees) unscheduled permanent disability for the back, as stated by the Referee. For the following reasons, we decline to alter the Referee's order.

The November 16, 1988 Determination Order awarded claimant 18 percent (24.3 degrees) scheduled permanent disability for his left foot. (Ex. 22). The May 16, 1990 Determination Order awarded 30 percent (45 degrees) scheduled permanent disability for claimant's left leg and stated that this award was "in lieu of" that granted by the November 16, 1988 Determination Order. (Ex. 77). However, the May 16, 1990 Determination Order was set aside in its entirety by the May 21, 1990 Determination Order. (Ex. 79).

The May 21, 1990 Determination Order awarded 26 percent (83.2 degrees) unscheduled permanent disability and 30 percent (45 degrees) scheduled permanent disability for the left leg. The insurer was ordered to pay $13,945. The order further provided: "This is the value allowed by this order only and does not include payments previously ordered." Id. The May 21, 1990 Determination Order was corrected by a November 14, 1990 Determination Order which stated, in pertinent part:

> "The Determination Order of May 16, 1990 was set aside in its entirety. The award allowed on the Determination Order dated May 21, 1990 was in lieu of that granted by the Determination Order dated May 16, 1990. The Department approves the deduction of any overpaid temporary disability on previously paid permanent disability from the amount the carrier is now ordered to pay, as indicated on the Determination Order dated May 21, 1990."

The November 1990 Determination Order made no reference to the November 1988 Determination Order and did not state that the May 21, 1990 permanent disability award was in lieu of the November 1988 award. Based on this record, there is no indication that the November 1988 Determination Order award was ever set aside or altered. Under the circumstances, that order has become final.

Furthermore, although the May 16, 1990 Determination Order stated that the award granted by that order was "in lieu of" the November 1988 award, the May 16, 1990 Determination Order was set aside in its entirety by the May 21, 1990 Determination Order. Neither the May 21, 1990 Determination Order nor the November 14, 1990 Determination Order provided that the awards granted were in lieu of the November 1988 award or in any way altered the November 1988 Determination Order. In addition, the May 21, 1990 Determination Order stated that the value it awarded did not include payments previously ordered.

In short, there is no indication that the November 1988 award was ever altered. The Department may or may not have intended to alter the November 1988 Determination Order. Based on this record, however, that order has not been modified and the award granted by that order stands. Accordingly, we agree with the Referee's statement that claimant's total scheduled award to date is 48 percent and total unscheduled award to date is 26 percent.

Offset

On review, claimant does not challenge the amount or existence of the overpayment, but contends that the insurer wrongfully withheld payment of the permanent disability awarded by the May 21, 1990 Determination Order and should only be allowed to offset against any future awards of permanent disability. We disagree and conclude that the insurer should be authorized to offset its overpayment against the unpaid balance of the May 21, 1990 Determination Order.

The Board may authorize recovery of overpayments, and its authority to do so is not limited to circumstances involving a Notice of Closure or Determination Order. SAIF v. Zorich, 94 Or App 661 (1989); Steven F. Sutphin, 44 Van Natta 2126 (1992); Steve E. Maywood, 44 Van Natta 1199 (1992).

Here, the insurer has an existing overpayment of temporary disability benefits, and has failed to pay a portion of a previous permanent disability award. Claimant is not substantively entitled to the overpaid temporary disability benefits and the insurer would normally be allowed to offset its overpayment against future awards. Under the circumstances presented here, we conclude that the insurer should be allowed to offset its overpayment against the $3,162.34 it still owes on the May 21, 1990 Determination Order, but not against the penalty assessed by the Referee.

Extent of Unscheduled Permanent Disability

Claimant appealed the May 21, 1990 Determination Order as well as the July 14, 1992 Determination Order. When two Determination Orders are consolidated for hearing, the "standards" in effect on the date of the latest claim closure apply to the rating of permanent disability. See Wade A. Webster, 42 Van Natta 1707 (1991); see also Every Mendenhall, 45 Van Natta 567, 569 (1993); Susannah Rateau, 43 Van Natta 135 (1991). The applicable standards are those in effect on July 14, 1992, the date claimant's claim was last closed. (WCD Admin. Orders 11-1992; 6-1992).

Claimant became medically stationary on March 15, 1990. Therefore, the amendments pertaining to the mandatory reconsideration process do not apply to his claim. See Or Laws 1990 (Special Session), chapter 2, §54(3). Thus, claimant was not required to seek reconsideration prior to requesting a hearing on the July 14, 1992 Determination Order. Because the amendments pertaining to the reconsideration process do not apply, claimant's permanent disability is rated at the time of hearing. Gettman v. SAIF, 289 Or 609, 614 (1980).

On review, claimant does not dispute the age (1) and education (3) factors determined by the Department, but seeks a higher adaptability factor. In addition, claimant seeks an award for lost ranges of motion based upon the findings of Drs. Coletti and Brooks.

Claimant contends that his job at injury was really in the very heavy range, rather than in the medium range as the Determination Order found. Claimant does not argue that a different DOT description more accurately describes his at injury job. Under the applicable standards, the adaptability factor is based on a comparison of the strength demands of the worker's job at time of injury with the worker's maximum RFC at time of determination. OAR 436-35-310(1). OAR 436-35-270(3)(g) provides that prior strength (physician demand) shall be derived from the strength category assigned in the DOT for the worker's job at injury.

We consider the record as a whole, including the job duties and the physical demands of the relevant job, in determining which DOT is most applicable. Nevertheless, the fact remains that the most applicable DOT determines the strength category. See OAR 436-35-270(3)(g); William D. Knox, 45 Van Natta 854 (1993). Claimant's testimony is relevant to the determination of which DOT most accurately describes his at-injury job. Kathyron D. Parsons, 45 Van Natta 954 (1993); however, claimant's testimony may not be relied upon to determine that no DOT description accurately describes his job, and that, therefore, his strength category must be determined without regard to the DOT. Id.

Here, claimant has not identified a particular DOT which describes his job more accurately than the DOT used by the Evaluations Division. Moreover, we have not found a DOT job description that is more appropriate for claimant's work than the description used by the Evaluations Division. Accordingly, we conclude that the Determination Order correctly identified claimant's adaptability factor as 5.

Claimant seeks an award for lost range of motion, based on the findings of Drs. Coletti and Brooks. These physicians examined claimant on behalf of the insurer. Claimant's attending physician, Dr. Wells, concurred with their report. Drs. Coletti and Brooks opined that claimant's range of motion findings were invalid. Accordingly, we do not rely on their invalid findings. However, in 1990, just prior to declaring claimant medically stationary, Dr. Wells found reduced range of motion in the thoracolumbar spine of 60 degrees flexion and 5 degrees extension. Thus, claimant is entitled to awards of 3 percent for reduced flexion and 2.5 percent for reduced extension. OAR 436-35-360(7),(8).

We compute claimant's unscheduled disability following the steps set out in OAR 436-35-280. Claimant's age (1) and education (3) values are added to equal 4. This value is multiplied by claimant's adaptability factor (5) to equal 20. This value is added to claimant's impairment value (5.5 for lost ranges of motion) to equal 25.5. This value is then rounded to 26 pursuant to OAR 436-35-007(13). Claimant's unscheduled permanent disability under the standards is 26 percent. Claimant has already received an award of 26 percent unscheduled permanent disability for his back condition in this claim. Thus, he has not established an entitlement to a greater unscheduled award for his back.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's cross-request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 6, 1993, as reconsidered on August 31, 1993 is affirmed. For services on review, claimant's attorney is awarded $750 payable by the insurer.

In the Matter of the Compensation of
JIM M. GREENE, Claimant
WCB Case No. 93-05310
ORDER ON REVIEW
Max Rae, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Hall, Westerband, and Haynes.

Claimant requests review of those portions of Referee Daughtry's order which: (1) increased his unscheduled permanent disability for a low back condition from 15 percent (48 degrees), as awarded by an Order on Reconsideration, to 20 percent (64 degrees); and (2) declined to assess a penalty pursuant to ORS 656.268(4)(f) or (g). On review, the issues are extent of unscheduled permanent disability and penalties. We modify in part and affirm in part

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

The Referee applied the disability standards in effect at the time of the September 8, 1992 Notice of Closure (WCD Admin. Order 6-1992), as amended by temporary rules effective June 17, 1993 and applicable to all permanent disability decisions made on or after that date (WCD Admin. Order 93-052).

Based on those rules, the Referee: (1) affirmed the 15 percent impairment rating made by the Order on Reconsideration, based on the measurements endorsed by the treating physician, instead of the medical arbiter's measurements; and (2) increased the unscheduled permanent disability award by 5 percent based on social/vocational factors, pursuant to temporary OAR 436-35-280 to 436-35-310.

In evaluating the social/vocational factors, the Referee determined that claimant's job at the time of injury is most accurately described by the Dictionary of Occupational Titles (DOT) code 913.663-018: "driver (motor trans), alternate titles: shuttle-bus driver, van driver." This DOT job classification requires "medium" strength. The Referee further found that claimant has the residual functional capacity (RFC) to perform his regular work. Therefore, based on temporary OAR 436-35-310, the Referee assigned an adaptability value of 1.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994). Accordingly, upon review we apply the "standards" in effect on September 8, 1992, the date of the Notice of Closure. (WCD Admin. Order 6-1992).

Impairment Rating

On review, claimant disagrees with the impairment rating and contends that it should be based on the medical arbiter's measurement of forward flexion (20 degrees for 7 percent impairment), rather than on the flexion measurement endorsed by the treating physician (39 degrees for 4 percent impairment). (See Exs. 13-3, 14, 17-3). Claimant contends he is entitled to a value of 18 percent for impairment, rather than the 15 percent awarded by the Order on Reconsideration.

We adopt and affirm the Referee's findings and conclusion regarding the impairment rating. We agree that, because the medical arbiter indicated that his measurement of forward flexion failed reproducibility testing (for whatever reason), the arbiter's measurement is entitled to less weight. Accordingly, we conclude that the preponderance of medical evidence establishes a different level of impairment than that measured by the medical arbiter for forward flexion. See former OAR 436-35-007(9); Doris E. Burnett-Stanbery, 45 Van Natta 737 (1993). Therefore, we affirm the 15 percent impairment rating made by the Order on Reconsideration.

Social/Vocational Factors

Claimant contends that he did not return to his regular job; therefore, he is entitled to values for social/vocational factors. Specifically, claimant contends that the DOT code used by the Referee, which correlates to "medium" strength, fails to cover the heavy lifting that was actually required by his job. On review, SAIF contends that this portion of the Referee's order should be affirmed.

As noted above, the appropriate standards for rating claimant's disability are in WCD Admin. Order 6-1992. Pursuant to former OAR 436-35-290(2), 436-35-300(2) and 436-35-310(2), for workers who have a physician's release to regular work, or who have returned to regular work at the time of the determination, the value for the age, education and adaptability factors is zero. "Regular work" is defined as "substantially the same job held at the time of injury, or substantially the same job for a different employer." Former OAR 436-35-270(3)(c). Accordingly, we turn to a determination of whether claimant was released to, or returned to, regular work.

First, claimant contends that his regular work is properly classified as "heavy." We agree.

To determine the proper DOT job description, we consider the record as a whole, as it relates to the worker's job duties as well as strength[1] demands, to find the position which most appropriately describes the worker's prior job. See William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993).

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[1] Job strength categories are defined in the disability standards, as follows. "Medium" work is defined as lifting 50 pounds maximum, with frequent lifting or carrying of objects weighing up to 25 pounds. "Heavy" work is defined as lifting a maximum of 100 pounds, with frequent lifting or carrying of objects weighing up to 50 pounds. "Very heavy" work is defined as lifting objects weighing more than 100 pounds, with frequent lifting or carrying of objects weighing 50 pounds or more. Former OAR 436-35-270(3)(g)(C), (D), (E).

Here, claimant testified that certain aspects of his job required heavy work: lifting patients, lifting wheelchairs with patients, moving patients' property, and subduing combative patients. (See Tr. 6-13; Ex. 1A-6). Indeed, claimant sustained his injury while moving a patient's property; claimant was required to lift a container weighing approximately 130 pounds. (Tr. 12-13).

Because we find that claimant's "heavy" duties were not merely incidental, but were a required and integral part of his job, we conclude that the most appropriate DOT code is 355.674-018 for "orderly." See William L. Knox, supra. This job description requires "heavy" strength. We find that it best describes the full range of claimant's job duties.

Next, we consider whether claimant was released to, or returned to, his regular work. Although claimant returned to his former job, he testified that he no longer performed the heavy lifting duties of his job. (Tr. 14-16). Rather, due to the benevolence of his co-workers and supervisors, claimant was able to avoid or get help with most heavy lifting duties. His physician also noted that, although claimant returned to his job, he was cautious about lifting and got help with any heavy lifting duties. (Ex. 13B). Because claimant, in fact, no longer performed the full range of his duties when he returned to work, we conclude that claimant did not return to his regular work. See George O. Hamlin, 46 Van Natta 491, 493 (1994) (claimant did not return to "regular" job when he returned to former bus driver job, but could no longer operate manual steering buses).

In addition, we find that claimant was not released by his attending physicians to "regular work." Dr. Moore, the attending physiatrist, released claimant to return to full duty at his former job; at the same time, however, he noted that claimant could lift and carry only 60 pounds. (Ex. 13A). Attending physician Dr. Buza agreed with Dr. Moore's release. (Ex. 14). In releasing claimant to "full duty" work, we presume that Dr. Moore was aware of the back rehabilitation program discharge summary, which suggests that claimant's full duty goals had been modified by the "accommodating employer." (Ex. 13-2). Moreover, Dr. Moore was aware that claimant avoided heavy lifting duties when he returned to work. (Ex. 13B). Inasmuch as we have found that claimant's regular job requires "heavy" strength,[1] whereas claimant's physical capacity upon his return to work was limited to lifting and carrying only up to 60 pounds, we conclude that claimant's attending physicians did not in fact release him to his "regular work."

Having found that claimant was not released to, nor did he return to, his regular job, we turn now to a determination of the values for age, education and adaptability.

Age

Claimant was 53 years old at the time of claim closure. Because he did not return to his regular work, he is entitled to a value of 1 for age. Former OAR 436-35-290(2).

Formal Education

Since claimant had received a high school diploma prior to the time of determination, he is assigned a value of 0 for formal education.

Skills

The skills value is determined by the highest Specific Vocational Preparation (SVP) achieved by a worker in the 10 years prior to determination. The SVP value is obtained from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT). To determine the skills value for a worker, the DOT job title for each job the worker performed during the 10 years prior to determination is identified. With respect to each job title, a determination is made whether the worker has met the SVP number assigned to such job by the SCODDOT. In order to meet the SVP number for a particular job, the worker must have "remained in the field" for the training time which corresponds to the SVP number assigned to that job title. See former OAR 436-35-300(4).

Here, claimant has held his present job for more than ten years prior to determination. We have previously determined that the most appropriate job title for claimant's job is "orderly," DOT code 355.674-018, which has an SVP value of 4. Therefore, claimant is entitled to a skills value of 3. Former OAR 436-35-300(4).

A worker who does not hold a current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less, and who has not achieved an SVP number of 5 or higher during the ten years prior to determination, is entitled to an additional skills value of 1. Former OAR 436-35-300(5).

Here, the Referee found that claimant does not hold a current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less. The Referee also found that claimant has not met an SVP of 5 or higher during the ten years prior to determination. Neither party contests the Referee's findings. Therefore, we conclude that claimant is entitled to an additional value of 1 under former OAR 436-35-300(5).

Claimant's total education value is 4, the sum of the values assigned by former OAR 436-35-300(3), (4) and (5). Former OAR 436-35-300(6).

Adaptability

The adaptability value is determined by a comparison of a worker's "prior strength" with his residual functional capacity (RFC). See former OAR 436-35-270(3)(d), (g); 436-35-310.

Here, we have already found that claimant's prior strength demand was "heavy." We now determine his RFC.

Upon discharge from the back rehabilitation program, claimant was found to be capable of lifting up to 20 pounds frequently, and up to 60 pounds occasionally. (Exs. 13-1, 13A). These lifting capacities fall within the "medium" strength category. Former OAR 436-35-270(3)(g). Dr. Martens, the medical arbiter who examined claimant on April 9, 1993, found him capable of "medium" category work. (Ex. 17-4). Accordingly, we conclude, based on the preponderance of medical evidence, that claimant's RFC is "medium."

Because we have found that claimant's prior strength demand was "heavy" and his RFC is "medium," claimant is entitled to a value of 3 for adaptability. Former OAR 436-35-310(3).

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value of 1 is added to his education value of 4, the sum is 5. When that value is multiplied by claimant's adaptability value of 3, the product is 15. When that value is added to claimant's impairment value of 15, the result is 30 percent unscheduled permanent partial disability. Former OAR 436-35-280.

Penalty

We adopt and affirm that portion of the Referee's order which declined to assess a penalty under ORS 656.268(4)(f) or (g). Cynthia L. Luciani, 45 Van Natta 1734 (1993) (penalty is available only if the requisite increase is awarded by the Department in its reconsideration order).

ORDER

The Referee's order dated August 30, 1993 is modified in part and affirmed in part. In addition to the Order on Reconsideration and Referee's awards of 20 percent (64 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability, for a total award of 30 percent (96 degrees) unscheduled permanent disability for his low back condition. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800, payable by the SAIF Corporation directly to claimant's attorney. The remainder of the Referee's order is affirmed.

Board Member Haynes dissenting in part.

Because I find that claimant returned to his regular work, which the Referee correctly classified as requiring "medium" strength, I dissent from that portion of the majority's order which found that claimant is entitled to values for social/vocational factors.

First, after my review of the record, I agree with the Referee's determination that claimant's prior work is properly classified as "medium," rather than "heavy." We are required to select the one DOT code which most accurately describes claimant's prior job, taking into consideration claimant's job duties as well as strength demands. Former OAR 436-35-270(3)(g); Thomas D. Porter, 45 Van Natta 2218, 2219 (1993). The most applicable DOT code determines the strength category for the prior job. Kathyron D. Parsons, 45 Van Natta 954, 955 (1993).

Here, claimant's job duties primarily entail transporting patients. (See Exs. 1A at 2, 4, 5; Tr. 5-6). Mail pick-up and delivery is a daily task which requires lifting up to 50 pounds, but this task requires only "medium" strength. (See Ex. 1A-5; Tr. 15). While claimant's job includes some duties which may require "heavy" strength, I find that the "heavy" strength tasks are no more than incidental to claimant's job. For example, transferring non-ambulatory patients occurs only 0-5 percent of the time on days spent transporting patients, and moving patient belongings occurs only occasionally (0-3 times per months). (Ex. 1A-5). I conclude that claimant's "heavy" job duties are not a significant aspect of his job. See Kathyron D. Parsons, supra; Christa Lee, 45 Van Natta 928 (1993).

Moreover, on review, claimant concedes that the DOT code used by the Referee "is probably the single best DOT code to describe claimant's general responsibilities," even though it does not encompass the heavy lifting requirements of his job. See Appellant's Brief at 5. That is the correct standard for determining the appropriate DOT code, and it is the standard the Referee applied. Accordingly, I conclude that the Referee correctly found that claimant's prior job is most accurately described by DOT code 913.663-018, "driver," which is classified as requiring "medium" strength.

Next, I find that claimant was released to and returned to his regular work. Claimant's treating physicians Drs. Buza and Moore released him to regular work in July 1992. (Exs. 13A, 14). Despite certain restrictions on bending, twisting, squatting, and reaching, the back rehabilitation program therapists advised that claimant could resume his regular duties, and that he was physically capable of lifting up to 60 pounds. (Exs. 13-1, 13A). The medical arbiter also found claimant capable of performing work in the "medium" strength category. (Ex. 17-4). Thus, I find that claimant was released to his regular job and was capable of performing "medium" strength work, the strength required by his regular job.

Furthermore, I agree with the Referee's finding that, despite assistance from his co-workers for heavy lifting assignments, claimant, in fact, returned to the same job he had when he was injured. See Harrison v. Taylor Lumber & Treating, 110 Or App 325 (1992); Thomas D. Porter, supra. Accordingly, I conclude that claimant was released to and returned to his regular work.

Because I find that claimant returned to his regular work, I also find that he is not entitled to any values for age, education or adaptability. Former OAR 436-35-290(2), 436-35-300(2), 436-35-310(2). Therefore, under the appropriate standards, claimant is not entitled to the additional 5 percent disability awarded by the Referee. However, because SAIF did not seek a reduction of the award made by the Referee, I would affirm the Referee's order.

In the Matter of the Compensation of
JUANITA C. HICKERSON, Claimant
WCB Case No. 93-05785
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Thye's order that: (1) found that a Notice of Closure did not prematurely close claimant's claim; and (2) affirmed an Order on Reconsideration awarding temporary disability from April 23, 1990 through November 26, 1990. On review, the issues are premature closure and extent of temporary disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In February 1988, claimant compensably injured her neck. A November 1990 Determination Order subsequently closed an aggravation claim. However, the Determination Order eventually was set aside by the Board's Order on Review on the basis that the claim was prematurely closed. The Board's order was affirmed without opinion by the Court of Appeals.

Pending such proceedings, the insurer issued a Notice of Closure on December 22, 1992 which found claimant medically stationary on November 26, 1990 and awarded temporary disability through that date. An Order on Reconsideration affirmed the Notice of Closure.

Premature Claim Closure

Claimant first challenges the Referee's conclusion that the claim was not prematurely closed. Specifically, claimant asserts that a valid closing examination was not performed, which violated OAR 436-10-030(10).

The test for determining premature claim closure depends upon whether claimant was medically stationary at the time of closure. ORS 656.268(1). In particular, a claim is not considered prematurely closed unless claimant proves that she was not medically stationary on the date of closure. Berliner v. Wyerhaeuser, 54 Or App 624, 628 (1981); Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). We agree with claimant that the attending physician is administratively required to "send a closing report to the insurer within 10 days of the examination in which the worker is declared medically stationary." OAR 436-10-030(1). However, because the rule merely provides a reporting requirement without necessarily resolving the issue of whether a claimant is not medically stationary, we find that any failure to satisfy the rule does not carry claimant's burden. Therefore, even assuming a failure to comply with the rule, we find no merit to claimant's argument and proceed to review the record to determine whether claimant was not medically stationary on the date of closure.

On October 25, 1990, Dr. Hendricks, claimant's treating physician, performed a closing examination finding claimant medically stationary with 12 percent permanent impairment. (Ex. 47). Dr. Hendricks also recommended restrictions during the first 60 days of employment, stating that claimant could then work without restrictions. (Id. at 5).

On June 6, 1992, Dr. Hendricks reevaluated claimant, finding a "normal neurological examination." (Ex. 59-4). In December 1992, Dr. Hendricks declared claimant medically stationary and released to regular work as of November 26, 1990. (Exs. 62, 63-3, 65, 71).

Finally, on March 10, 1993, claimant underwent a medical arbiter examination. Although noting permanent disability, the medical arbiter did not indicate that claimant was not medically stationary. (Ex. 68).

We find no evidence that claimant was not medically stationary when the December 1992 Notice of Closure issued; instead, we find that the record shows that claimant was medically stationary as early as November 26, 1990. Therefore, we find no premature closure by the December 1992 Notice of Closure.

Extent of Temporary Disability

Claimant further asserts that she has a procedural entitlement to temporary disability benefits until her claimant has been properly closed. We disagree. First, we have found that the claim was not prematurely closed. Furthermore, based on evidence that claimant proved disability until November 26, 1990, we find that she is substantively entitled to such benefits through that date. (Exs. 62, 63-3, 65, 71). See SAIF v. Taylor, 126 Or App 658 (1994). Inasmuch as the December 1992 Notice of Closure awarded temporary disability through November 26, 1990, claimant is not entitled to additional temporary benefits, even if she had a procedural entitlement. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992).

ORDER

The Referee's order dated November 29, 1993 is affirmed.

July 27, 1994 Cite as 46 Van Natta 1533 (1994)

In the Matter of the Compensation of
ROSE M. LeMASTERS, Claimant
WCB Case No. 93-03613
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The self-insured employer requests review of Referee Barber's order that: (1) set aside its denial of claimant's back condition; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the employer contends that the Referee abused his discretion by not considering claimant's employment records which had been admitted into the record under an offer of proof. On review, the issues are compensability, penalties and evidence. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the following supplementation.

Claimant previously injured her back in a motor vehicle accident in approximately 1972.

We take administrative notice of the following facts, contained in a prior referee's order dated November 29, 1988. The Referee admitted the prior Opinion and Order under an offer of proof, but did not consider the prior order in reaching his decision.

On June 12, 1988, claimant irritated her back while riding in her family's boat. On June 13, 1988, claimant sustained an injury while working in a prior employer's retail store. Claimant could not complete the workday, and her low back, right hip and leg pain were so severe that she could not bend over and could barely walk. Claimant was taken to a hospital by ambulance.

Following the June 1988 incident, claimant received treatment from Dr. Erickson, D.O. Claimant filed a claim for her low back, which was denied by the prior employer's insurer. Claimant requested a hearing from the insurer's denial.

In a November 29, 1988 Opinion and Order, a prior referee upheld the insurer's denial. The prior referee found claimant's claim not compensable, based on the treating doctor's incomplete history. The prior referee found that the doctor had an incomplete history due to claimant's failure to inform him of her previous stiff back which resulted from boating.

On December 7, 1992, claimant was working as a bus driver for the self-insured employer. While steering the bus, claimant felt a pop in her back following a turn from one street onto another. Claimant sought treatment from Dr. Clifton, chiropractor. Her condition was diagnosed as a right sacral sprain and mid-thoracic strain.

Claimant did not inform her doctor of her prior back problems.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee received certain exhibits pursuant to an offer of proof. On review, the employer contends that the Referee erred in not considering those exhibits. We disagree.

ORS 656.283(7) provides that the "referee is not bound by common law or statutory rules of evidence *** and may conduct the hearing in any manner that will achieve substantial justice." That statute gives the Referee broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). Moreover, OAR 438-07-017 provides that evidence "reasonably believed relevant and material only for purposes of impeachment of a witness *** may be offered and admitted solely for impeachment." (Emphasis supplied.) Because the language of that rule is permissive, the Referee has discretion to decide whether to admit impeachment evidence offered under that rule. See, e.g., Dean L. Watkins, 43 Van Natta 27, 529 (1991). Consequently, we review for an abuse of discretion.

Here, the employer has submitted employment records in an attempt to show that claimant was employed during a time she was collecting unemployment benefits, and thus, was receiving those benefits under false pretenses. We conclude that the Referee did not abuse his discretion by declining to consider such evidence. Such evidence (of prior "bad acts") is generally not admissible in court, because its probative value is deemed to be outweighed by the danger of unduly prejudicing the adjudicator. See ORS 40.170(3); OEC 404(3); Portland Mobile Home Park v. Wojtyna, 85 Or App 368 (1987) (Evidence of prior act excluded where probative value substantially outweighed by danger of unfair prejudice). That danger would be no less real in this forum. Accordingly, the Referee did not abuse his discretion in declining to consider the evidence.

Compensability

The Referee found that claimant did not intend to deceive anyone about the prior 1988 workers' compensation claim for her low back, which claimant testified that she had forgotten about. The Referee further found that the omitted information did not materially affect claimant's treating doctor's opinion regarding causation. The Referee, therefore, set aside the employer's denial. We reverse.

The Referee found claimant to be a credible witness. However, the Referee did not base his demeanor finding on credibility. Accordingly, we assess claimant's credibility based on the substance of the evidence, rather than demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984). For the following reasons, we conclude that claimant is not credible.

Claimant told the employer's investigator that the only back problems she had which might be relevant were the problems she experienced as a result of the 1972 auto accident. At hearing, when questioned on cross-examination regarding her prior low back workers' compensation claim, claimant testified that she "wouldn't call it back problems," and she "simply didn't remember" the prior claim, until recent discussions with friends.

After reviewing the record, we do not find it likely that claimant would remember her back being injured in a 1972 motor vehicle accident, but she could not remember a back injury which occurred in 1988 allegedly at work (and while boating), and which was so severe that it required a trip to the hospital. Moreover, claimant received treatment for the 1988 incident, filed a workers' compensation claim and proceeded to a hearing on the low back claim after her former employer denied the claim. Therefore, claimant had every reason to remember the 1988 injury and claim.

In addition, after being confronted with the fact of the 1988 injury and claim, claimant testified that her back condition had resolved within six weeks of the 1988 injury. However, claimant conceded that in January 1990, on an employment form, she claimed a lifting restriction of ten pounds or less, due to her "lower sacrolumbar injury" of 1988. Therefore, presumably, claimant continued to have back problems in 1990, even though she apparently was not receiving any treatment at that time.

Considering the aforementioned circumstances, we do not accept claimant's testimony that she did not remember the 1988 incidents until she discussed them with friends because she did not consider them to involve a "back problem." We also do not accept claimant's testimony that her 1988 injury had completely resolved within six weeks after the injury. In short, we conclude that claimant was not a credible witness, and her testimony cannot be relied upon to establish the nature and extent of her prior back problems and her medical status at the time of the 1992 incident.

Finally, we conclude that the present case requires expert medical evidence. In Barnett v. SAIF, 122 Or App 279, 283 (1993), the court held that factors for determining whether expert testimony of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, we conclude that, based on the 1990 work restriction of 10 pounds, due to her prior lumbar injury, claimant was not free from disability of the kind involved in the injury sustained with the present employer. Consequently, expert medical opinion is required to establish compensability.

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are several reasons not to defer to Dr. Clifton, claimant's treating chiropractor.

As discussed previously, at hearing claimant acknowledged that she had sustained a low back injury in the early 1970's and that she had been treated for a low back condition in 1988. Moreover, claimant reported continuing work restrictions, due to her low back problem, in 1990.

It is clear that Dr. Clifton had no knowledge of any prior back problems experienced by claimant. Claimant conceded at hearing that she had not informed Dr. Clifton of her prior back claim. Additionally, there is no evidence that claimant informed Dr. Clifton of her earlier motor vehicle injury involving her back, or of any continuing back condition which would require a ten-pound lifting restriction.

Therefore, we find that, because it is based on an incomplete history, Dr. Clifton's opinion is not persuasive. Somers v. SAIF, 77 Or App 259 (1986). Furthermore, because Dr. Clifton had an incomplete history, he was precluded from considering other potential causes which could have contributed to claimant's low back condition. See Troy L. Noel, 45 Van Natta 2048 (1993) (Doctor who was unaware of claimant's off-work incident involving the same body part was unpersuasive as it was based on an incomplete history). We, thus, do not rely on Dr. Clifton's opinion. There is no other medical evidence in the record to establish causation. Claimant has, therefore, failed to establish the compensability of her claim.

Penalty

The Referee assessed a penalty for the employer's allegedly unreasonable denial. Because we have reversed the Referee on the issue of compensability, there are no amounts due on which to base a penalty, and there has been no unreasonable resistance to the payment of compensation. Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Consequently, we reverse the penalty award.

ORDER

The Referee's order dated August 31, 1993 is reversed. The self-insured employer's denial of February 15, 1993 is reinstated and upheld. The Referee's penalty award and assessed attorney fee award of $2,800 are also reversed.

In the Matter of the Compensation of
DANIEL C. REDDEKOPP, Claimant
WCB Case No. 92-14452
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Garaventa's order that dismissed his request for hearing on the issue of the SAIF Corporation's de facto denial of his aggravation claim. On review, the issues are jurisdiction and aggravation. We reinstate claimant's hearing request and set aside SAIF's de facto denial.

FINDINGS OF FACT

Claimant, a working partner in a heavy construction and land development business, sustained a compensable, disabling low back sprain on August 6, 1983. (Exs. 2 and 14). The claim was closed by a May 4, 1984 Determination Order awarding temporary disability only. (Ex. 7). Claimant subsequently underwent a bilateral laminectomy and disc surgery at L4-5. On December 2, 1986, he underwent a repeat bilateral laminectomy at L5 and partial bilateral laminectomy at L4, with removal of the disk and adhesions from the prior surgery. (Ex. 11). Claimant continued to work off and on in his business before and after his back surgeries. (Ex. 14-2). A December 10, 1987 Determination Order awarded temporary disability, 35 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the right leg. (Ex. 12).

A December 8, 1988 Opinion and Order granted claimant permanent total disability (PTD). (Ex. 24). This order was reversed by a June 18, 1990 Order on Review, which reinstated the December 10, 1987 Determination Order. (Ex. 31).

Dr. Collada, neurological surgeon, examined claimant on February 21, 1989, March 17, 1989, March 29, 1989, and April 18, 1989. SAIF received the chart notes and Collada's April 18, 1989 request for authorization of cervical surgery prior to May 4, 1989, the date claimant's aggravation rights would terminate, but neither accepted nor denied the claim prior to that date.

On May 5, 1989, SAIF partially denied claimant's cervical condition. (Ex. 21). This denial was upheld by a September 28, 1989 Opinion and Order and an October 31, 1990 Order on Review. (Exs. 23 and 34).

On December 13, 1989, claimant underwent surgery.

On July 3, 1991, the Court of Appeals reversed the Board's order and remanded it to the Board for reconsideration. (Ex. 38). On October 22, 1991, the Board set aside the denial. (Ex. 43).

On June 11, 1992, the Board issued an Own Motion Order in response to SAIF's request. The Board authorized the reopening of claimant's claim for the payment of temporary total disability compensation beginning the date claimant underwent surgery. (Ex. 48).

On June 12, 1992, SAIF issued a Notice of Closure closing claimant's claim under own motion (Form 2066). (Ex. 46).

On August 7, 1992, claimant objected to the Notice of Closure on the basis that the claim should have been reopened as an aggravation. (Ex. 50).

On October 7, 1992, the Board issued an Own Motion Order Reviewing Carrier Closure, declining to reconsider the June 11, 1992 Own Motion Order on the basis that claimant had not requested review timely under OAR 438-12-065(2). (Ex. 52). The Board stated that, were it to reach the merits of claimant's claim, it would find that claimant's condition did not worsen prior to the expiration of his aggravation rights. Thus, it would find that the case was properly processed under its own motion authority pursuant to ORS 656.278.

On November 4, 1992, claimant requested a hearing, raising the issue of a "de facto" denial of an aggravation claim.

FINDINGS OF ULTIMATE FACT

Claimant perfected an aggravation claim prior to the expiration of aggravation rights on May 4, 1989.

Prior to May 4, 1989, claimant experienced a worsened condition since the last award of compensation.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that the issue of whether claimant had perfected an aggravation claim prior to the expiration of his aggravation rights had already been decided by the Board in a prior own motion order. The Referee dismissed claimant's request for hearing after concluding that the Hearings Division did not have jurisdiction to consider the matter. Claimant contends that the Referee had jurisdiction to address the merits of the aggravation claim because he had perfected an aggravation claim prior to the expiration of his aggravation rights. We agree.

Issue preclusion applies to an issue of either fact or law when an issue of fact or law is actually litigated and determined by a valid and final judgment, and the determination is essential to the judgment. Drews v. EBI Companies, 310 Or 134, 140 (1990) (citing Restatement (Second) of Judgments § 27). Claim preclusion likewise requires a valid and final judgment. Id. at 141.

An own motion order is not valid if a claimant perfects an aggravation claim prior to the expiration of aggravation rights. Linda Coiteux, 43 Van Natta 364, 367 (1991). If claimant timely perfected an aggravation claim, then the Board does not have own motion jurisdiction and its June 11, 1992 Own Motion Order authorizing the reopening of claimant's claim and its October 7, 1992 Own Motion Order Reviewing Carrier Closure are not valid final judgments and are without legal effect. See id. Without a valid final judgment, it is inappropriate to bar claimant's request for hearing based on that judgment. Accordingly, our first inquiry is whether claimant perfected an aggravation claim prior to the expiration of his aggravation rights.

To establish an aggravation claim, "the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened." Glean A. Finley, 43 Van Natta 1442, 1444 (1991); Herman M. Carlson, 43 Van Natta 963, 964 (1991), aff'd Carlson v. Valley Mechanical, 115 Or App 371 (1992). The report must indicate a causal connection between claimant's "worsened" condition and the compensable injury. Carlson, supra; Michael L. Page, 42 Van Natta 1690, 1693 (1990).

The record shows that, subsequent to an October 1988 PTD hearing (see Ex. 20-1), Dr. Collada's chart notes reported that claimant was having "more problems ambulating," "more problems in the right upper back region," and "paresthesias down the right upper extremity." (Ex. 13C-1). SAIF received those chart notes in April 1989. Dr. Collada's April 18, 1989 chart note shows that Collada called SAIF's examiner to request authorization for cervical surgery. (Ex. 16-1). When the examiner asked for the request in writing, Dr. Collada sent a letter stating that claimant's cervical pathology may be the reason for claimant's problems and that claimant wanted to proceed with cervical decompression surgery. (Ex. 18).

SAIF interpreted Collada's April 18, 1989 letter as a request for surgery allegedly relating to the compensable injury. SAIF sent the letter and the medical record to its Medical Advisor, Dr. Norton, for assessment. Although Dr. Collada's letter is date-stamped as received on "August 10, 1992" by SAIF, inasmuch as Dr. Norton mentions the letter in his May 1, 1989 report (Ex. 20-2), and Dr. Norton presumably received the letter from SAIF, we can assume that SAIF received the letter prior to May 4, 1989, the date on which claimant's aggravation rights expired. SAIF issued a denial of the cervical condition on May 5, 1989. (Ex. 21).

Based on Dr. Collada's chart notes and the April 18, 1989 letter, we find that SAIF was put on notice of a worsened condition allegedly relating to the compensable injury prior to May 4, 1989. We consequently conclude that claimant timely perfected an aggravation claim prior to the expiration of his aggravation rights.

Because claimant perfected an aggravation claim prior to the expiration of his aggravation rights, the Board's own motion orders were not valid final orders because the Board did not have own motion jurisdiction. See ORS 656.278 and Linda Coiteux, supra. Consequently, the own motion orders do not have a preclusive effect on claimant's aggravation claim.

Aggravation

The parties agreed to submit this matter on the record without going to hearing. Consequently, we address the merits of claimant's aggravation claim.

In order to establish a compensable aggravation, claimant must prove that his condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396, 401 (1986). Furthermore, because claimant received a previous permanent disability award for his condition, he must establish that any worsening is more than a waxing and waning of symptoms if such was contemplated by the previous permanent disability award. ORS 656.273(8). Finally, claimant must establish that his worsened condition occurred prior to the expiration of his aggravation rights. Perry v. SAIF, 93 Or App 631, 633 (1988); rev'd on other grounds, 307 Or 654 (1989).

Subsequent to SAIF's partial denial of claimant's cervical condition, the Board reversed claimant's PTD award and reinstated the December 10, 1987 Determination Order that awarded 35 percent unscheduled permanent disability and 5 percent scheduled disability for his right leg. This award was based on claimant's low back and right leg conditions, as his cervical condition had not yet been identified. (See Ex. 43). There are no contemporaneous medical reports establishing that claimant's permanent disability award contemplated future waxing and waning of symptoms. Therefore, it is unnecessary to determine whether claimant's current symptoms exceeded any contemplated fluctuating symptoms. See ORS 656.273(8); Allen G. Hall, 45 Van Natta 2025 (1993).

However, even if such symptoms were contemplated, Dr. Collada's February 21, 1989 and subsequent reports regarding claimant's spastic gait as a result of his compensable cervical pathology and his subsequent request for cervical surgery establish that claimant's current symptoms were more than a waxing and waning of contemplated symptoms. (See Exs. 13C-1, 16-1 and 18).

At the time of claim closure, claimant was able to perform modified, part-time work. In contrast, subsequent to that time, he developed a spastic gait which was eventually found to be a result of cervical cord pathology. In May 1988, Dr. Flaming stated that claimant had not worked since his surgery and was unable to work as a result of his falls, fractured ribs, low back pain and spastic gait. (Ex. 12A). Even though Dr. Flaming was mistaken in his belief that claimant had not worked since his surgery, we find no reason to reject his conclusion that claimant was unable to work, given his new and worsened symptoms. Castle & Cooke, Inc. v. Porras, 103 Or App 65, 68 n.3 (1990) (The Board can accept a doctor's opinion on one aspect of a case but reject it on another aspect).

Furthermore, even though claimant continued to work until October 1988, he performed that work in his own business and increasingly took time to lie down to relieve his worsening symptoms. By October 1988, claimant was no longer able to continue any kind of work due to his increased symptoms. In his chart notes beginning in February 1989, Dr. Collada determined that claimant required cervical surgery to correct the pathological cervical cord condition. Moreover, as noted above, claimant's award of permanent disability in the Determination Order was based on his low back condition and surgeries, as the cervical back problems had not yet been identified. Consequently, we find that the record as a whole establishes claimant's diminished earning capacity as a result of his worsened condition. In addition, claimant has shown that his loss of earning capacity due to his worsened condition occurred prior to the May 4, 1989 expiration of his aggravation rights. See Perry v. SAIF, supra.

Accordingly, we conclude that the medical evidence establishes that claimant sustained a compensable worsening of his low back and cervical conditions since the last award of compensation. He has, therefore, proven a compensable aggravation claim.

Claimant is entitled to an assessed attorney fee for services at hearing and Board review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated June 8, 1993 is reversed. Claimant's hearing request is reinstated. The SAIF Corporation's de facto denial of claimant's aggravation claim is set aside, and claimant's aggravation claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
BONNIE A. STAFFORD, Claimant
WCB Case Nos. 93-09174 & 93-08558
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys
Betsy Byers (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 13, 1994 Order On Review that: (1) affirmed the Referee's order setting aside EBI's denial of claimant's claim for carpal tunnel syndrome; (2) assessed attorney fees against both EBI and SAIF for claimant's counsel's services in obtaining pre-hearing concessions of compensability; and (3) declined to assess an attorney fee under ORS 656.382. Specifically, SAIF contends that, because claimant failed to request an assessed attorney fee under ORS 656.386(1) against SAIF, we should not have awarded such a fee. After reviewing SAIF's motion, we continue to adhere to our prior conclusion. However, we offer the following supplementation to our previous decision.

SAIF contends that claimant failed to raise, at hearing and on Board review, the issue of entitlement to an ORS 656.386(1) attorney fee payable by SAIF. SAIF, thus, contends that we should not have considered the issue on review.

We do not read the Referee's recitation of the issues as narrowly as SAIF. Although claimant indicated, at hearing, that she would be asserting that EBI was responsible for her claim, her request for an assessed attorney fee was not expressly limited to EBI. SAIF's counsel did not object to the Referee's statement of the issues. (Tr. 3). Consequently, we find that the issue of claimant's entitlement to an attorney fee under ORS 656.386(1) was raised at hearing.

Moreover, the Board may make such disposition of a case as determined to be appropriate. Destael v. Nicolai Co., 80 Or App 596 (1986). The Board's review authority extends to all issues decided by the Referee's order. Alden D. Muller, 43 Van Natta 1246 (1991). Therefore, our review is not limited to the issue of whether claimant's counsel is entitled to an assessed fee only against EBI. Moreover, deciding that claimant is entitled to an attorney fee necessarily also includes deciding who is liable for that fee.

On Board review, EBI appealed the Referee's award of an assessed fee under ORS 656.386(1) contending there was no basis for a fee where the sole issue is responsibility. Because responsibility was the sole issue at hearing, we agree that claimant is not entitled to an assessed fee under ORS 656.386(1) for services performed at hearing. See Multnomah County School District v. Tigner, 113 Or App 405, rev den 311 Or 150 (1991). However, for the reasons stated in our prior decision, claimant is entitled to an assessed fee under ORS 656.386(1) for obtaining both insurers' pre-hearing withdrawals

of the compensability portion of their denials. See John W. Wantowski, 46 Van Natta 1158 (1994); Dale A. Karstetter, 46 Van Natta 147 (1994).

In finding that claimant was entitled to a fee, we reasoned that EBI's disclaimer in conjunction with its denial created an issue concerning the compensability of the claim. However, since SAIF's disclaimer and denial also raised compensability as an issue, both EBI and SAIF created the need for claimant to establish the compensability of her claim. Consequently, we continue to hold that both insurers are separably liable for claimant's counsel's attorney fees for obtaining pre-hearing rescissions of both insurer's compensability denials.

Accordingly, our July 13, 1994 order is withdrawn. On reconsideration, we adhere to and republish our July 13, 1994 order in its entirety, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL W. THOMPSON, Claimant
WCB Case Nos. 93-02236 & 93-02235
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Davis' order which determined that he was not a subject employee. On review, the issue is subjectivity.

We adopt and affirm the Referee's order with the following supplementation.

Claimant sustained multiple head and facial injuries when struck by a piece of scaffolding at a construction site. Claimant alleged he was an employee of Gonzales Plastering, a noncomplying employer. The Referee determined that, while claimant was an employee of Gonzales at a previous construction site (Black Oak), claimant failed to sustain his burden of proving that the employment relationship continued at the injury site (Cloudcrest). Therefore, the Referee upheld the SAIF Corporation's denials on behalf of Gonzales and the general contractor at Cloudcrest, Jay Landis Construction, also a noncomplying employer.

On review, claimant initially contends that, absent a termination of his employment upon completion of the Black Oak construction project, his employment relationship with Gonzales continued at the Cloudcrest site. Moreover, claimant asserts that, inasmuch as he was not a trespasser or an independent contractor at Cloudcrest, he must have been working for Gonzales. We disagree.

Claimant must prove the existence of an employment relationship. Konell v. Konell, 48 Or App 551, 557 (1980), rev den 290 Or 449 (1991). Claimant also has the burden of proving subject worker status. Douglas Fredinburg, 45 Van Natta 1060, 1061 (1993). Based on our review of the record, we conclude that claimant has failed to sustain his burden of proof.

Apart from claimant's hearsay testimony regarding statements made by Jerry Gonzales, owner of Gonzales Plastering, there is no evidence of any intention to continue claimant's employment beyond the work done at Black Oak. Jerry Gonzales never testified. Witnesses Nichols and Oldham, who testified on claimant's behalf, confirmed, at most, claimant's employment at Black Oak, which is not at issue. They did not corroborate claimant's employment at Cloudcrest, where Nichols and Oldham never worked. Most importantly, claimant's witnesses provided no evidence on the issue of whether Gonzales intended to continue claimant's employment after completion of the work at Black Oak.

Given the sporadic and informal nature of Gonzales' business, we are unwilling to infer any intent to continue claimant's employment beyond Black Oak in the absence of direct evidence of such intention. We do not consider claimant's hearsay testimony sufficiently reliable to establish a continuing employment relationship. Nor do we accept claimant's argument that he must have been working for Gonzales if he was not an independent contractor or a trespasser. Instead, we find it far more likely that claimant was a volunteer when he was injured.

As the Referee noted, claimant informed the hospital emergency room where he was taken after his injury that he was unemployed. (Ex. 1). Witness Morretti testified that claimant told him that he was seeking work at the Cloudcrest site. (Tr. II, pps. 15, 22). Morretti also told the investigator for the Department the same thing. (Ex. 2-9). Unlike witness Nichols, who was once involved in a heated disagreement with Gonzales, Morretti had no apparent bias. In addition, Mr. Landis testified, as did others at the hearing, that it is a common occurrence for individuals to show up at construction sites looking for work. (Tr. II, p. 104). It is also not uncommon for persons desiring employment to volunteer their labor in order to demonstrate competence to a potential employer. (Tr. II, pps. 49, 85).

In light of the above evidence, it does not necessarily follow that claimant was an employee merely because there is no contention that he was an independent contractor or a trespasser. Instead, we find that the most likely explanation for claimant's presence at the Cloudcrest site was as an individual seeking employment.

In his reply brief, claimant urges the Board to find the testimony of the employer's witnesses incredible or unreliable. Claimant contends that his testimony, as well as that of witnesses Nichols and Oldham, support a conclusion that he was an employee of Gonzales when injured.

We agree with the Referee that the evidence is conflicting on the issue of whether claimant was a subject employee. However, for the reasons previously discussed, there is insufficient evidence to establish, at the time of claimant's injury, either an express or implied contract of employment or a right of control in the putative employer over claimant. See Hix v. SAIF, 34 Or App 819, 825 (1978). We, therefore, agree with the Referee's finding that claimant has failed to sustain his burden of proof. Thus, we affirm the Referee's decision on the subjectivity issue.

ORDER

The Referee's order dated September 30, 1993 is affirmed.

In the Matter of the Compensation of
CHARLES D. TURNER, Claimant
WCB Case No. 92-11773
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Hall, Westerband and Haynes.

The SAIF Corporation requests review of Referee Brown's order which: (1) set aside its denial of claimant's right leg injury claim; and (2) assessed a penalty for allegedly unreasonable denials. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

Claimant injured his right leg on August 10, 1992, when a tree fell on him while operating a Cat. The timber fallers and catskinners operate according to a logging plan. Claimant's supervisor, Guy Remstedt, instructed the Cat operators, Stanfield and claimant, where to operate. Stanfield was working uphill and left of the landing, and claimant was working on a skid trail next to Stanfield. (Tr. 204-205, 216). Remstedt had also instructed the Cat operators to stay on marked skid trails. The logging contract requires that the Cat operators stay within the skid trails. (Tr. 86-87, 125). The skid trails are marked by fluorescent pink flags. The skid trails must be marked and BLM approved before logging can start. Occasionally the trails are reflagged after the fallers cut the trees. (Tr. 28, 113). Skid trails converge to a landing where the logs are loaded onto log trucks.

Normal operating procedures require that the Cat operators do not work where the timber fallers are still cutting trees (Tr. 147-48); see also OAR 437 Division 6. Claimant was injured in an area where timber faller, Bowen, was still cutting trees. Bowen had been cutting trees in that area the morning of the accident.

Claimant has been a recreational marijuana user for about 20 years. (Tr. II: 143, 147). As part of claimant's pre-employment evaluation, this employer arranged for claimant to undergo a chemical dependency evaluation (Tr. 117-122). The pre-employment screening indicated a co-dependency, but no evidence to substantiate a chemical dependency on marijuana. The evaluation concluded with a recommendation that claimant be allowed to work. (Ex. OA, OAA, OB). The day before the accident, claimant smoked two to three pipefuls of marijuana between 4:00 p.m. and 6:00 p.m. (Tr. II: 127-128, 145). The accident occurred at approximately 10:00 a.m. on Monday, August 10, 1992. Urine drug testing was performed somewhere between 12:25 p.m. and 3:08 p.m. on August 10, 1992. (Exs. 3C, 9). One method of testing indicated a value higher than the test's highest caliber, which was 135 ng/ml. Dr. Barclay, toxicologist, who reviewed this test result, reported that even with severe and unusual exposure to marijuana smoke, values rarely exceed 20-30 ng/ml. (Ex. 9). Another testing method measured the concentration of the THC metabolite at 253 ng/ml. (Ex. 11).

Dr. Swanson reported that, based on the immunoassay screening procedure used, the result was consistent with marijuana use within a time period of a few days before collection of the sample. (Ex. 11). Based on the result of three different analytical assays, Dr. Nahas opined that such an elevated concentration of the THC metabolite would create a strong presumption or indication that claimant had ingested marijuana within hours or days preceding collection of the sample and, further, that these measurements indicated that claimant's memory, judgment, and performance "could" have been impaired. (Exs. 14, 15). Claimant testified that marijuana has a relaxing effect and slows down time for him (Tr. II, p. 159). However, claimant testified that he did not feel impaired by having smoked marijuana the day before the accident (Tr. II, p. 140).

CONCLUSIONS OF LAW AND OPINION

The Referee found that: (1) claimant was not expressly prohibited from operating his Cat on or near the area of the accident; (2) the accident occurred in an area in which claimant reasonably could be expected to perform his work; and (3) claimant was on a designated skid trail at the time of the accident. Relying on the "ultimate work" test propounded by Professor Larson, infra, the Referee concluded that claimant did not violate work orders and, therefore, the accident occurred within the course and scope of employment.

The test for determining whether an employee's misconduct involved activities that are outside the course and scope of employment is stated by Professor Larson:

> "When misconduct involves a prohibited overstepping of the boundaries defining the ultimate work to be done by the claimant, the prohibited act is outside the course of employment. But when misconduct involves a violation of regulations or prohibitions relating to the the method of accomplishing that ultimate work, the act remains within the course of employment." 1A Larson, Workmen's Compensation Law 6-10, §31.00 (1990). (Emphasis in original.)

SAIF contends that claimant engaged in misconduct when he operated his Cat outside the designated skid trail and when he entered the area where timber fallers were working. SAIF further argues that driving the Cat near the timber fallers was in violation of logging industry standards and that these standards define the boundaries of safe logging practices. SAIF, thus, contends that claimant's misconduct was a deliberate overstepping of the boundaries defining the ultimate work to be done.

Here, we find that claimant's misconduct involved a violation of the employer's rules and the logging industry standards governing the method of accomplishing his ultimate job duties. Claimant was assigned to work on a skid trail located uphill from the landing. (Tr. 205, II Tr. 94) He was not working on that skid trail when the accident occurred. Testimony establishes that claimant was not where he was supposed to be when the accident occurred. Remstedt testified that claimant was about

300 yards away from where he should have been working. (Tr. 147). Stanfield testified that he thought claimant was supposed to be working on a different skid trail than where the accident occurred, and that the skid trail where claimant had been instructed to work still had trees to skid. (Tr. 217-219). Hunter, a timber faller, testified that earlier that morning he had not observed any Cats operating in the area where the accident occurred. (Tr. 227). Bowen, timber faller foreman, testified that the logging plan in effect on the day of the accident, did not include skidding logs in the area where the accident occurred. Rather, the skidders were to be above the landing and to the left of where the accident occurred. (Tr. 94, 97; Ex. 27-7). The accident, however, occurred in an area to the right of the landing. Claimant testified that, prior to the accident, he had been skidding on every skid trail. (Tr. II: 124). When the accident occurred, claimant was heading toward an area of uncut trees. However, he was in an area where there were fallen trees.

Bowen was falling trees over the skid trail that claimant would have been on if he was on a designated skid trail. (Tr. II: 52, 56). If claimant had been on that skid trail, a bigger portion of tree would have hit him. (Tr. 65). In addition, it was necessary to construct an access to the accident scene. (Tr. 31, 118). Based on the above, we find that claimant was not on a designated skid trail when the accident occurred.

Although claimant was not on a designated skid trail at the time of the accident, his disregard of the employer's instructions and the logging industry standards involved a violation of the method of accomplishing his ultimate work. Claimant was injured while performing his assigned job of skidding logs. Only the method, i.e., leaving a designated skid trail, in which he performed his work, was prohibited. When claimant left a designated skid trail he did not overstep the boundaries of the log skidding work that he was to do for the employer. In addition, the logging industry standards define the safe methods in which skid operators work with timber fallers. Thus, we conclude that claimant's misconduct involved a violation of a regulation or prohibition relating to the method of accomplishing his work. Claimant, therefore, remained within the scope of his employment. Patterson v. SAIF, 64 Or App 652 (1983); cf. Davis v. R & R Truck Brokers, 112 Or App 485 (1992).

Next, SAIF contends that claimant's consumption of marijuana was the major contributing cause of the injury, and therefore, under ORS 656.005(7)(b)(C), the claim is not compensable.

Under ORS 656.005(7)(b)(C), claimant must first establish a prima facie case of compensability. If so established, then to defeat a finding of compensability, SAIF must prove, by clear and convincing evidence, that claimant's unlawful consumption of a controlled substance was the major contributing cause of the injury. To be clear and convincing, the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). SAIF cannot meet its burden by merely showing that claimant consumed a controlled substance. Rather, SAIF must clearly and convincingly establish that claimant was impaired by the controlled substance and that such impairment was the major contributing cause of the injury. Grace L. Walker, 45 Van Natta 1273 (1993) aff'd mem 126 Or App 313 (1994); Dave D. Hoff, 45 Van Natta 2312 (1993). The issue is, then, one of causation.

SAIF does not contest that claimant's disability was materially related to the accident. We have also found that the accident occurred within the course and scope of employment. Therefore, SAIF must prove by clear and convincing evidence that claimant's consumption of marijuana was the major contributing cause of the accident. Grace L. Walker, supra. SAIF has failed to carry its burden of proof.

The uncontroverted medical evidence establishes that claimant is a chronic user of marijuana and that he had consumed marijuana days or hours prior to the accident. However, Dr. Nahas' opinion is insufficient to carry SAIF's burden of proof, since it fails to establish within reasonable medical probability a causal relationship between claimant's marijuana consumption and the on-the-job accident. See Gormley v. SAIF, 52 Or App 1055 (1981). SAIF has failed to establish, by clear and convincing evidence, that the major contributing cause of the accident was claimant's consumption of marijuana. See Grace L. Walker, supra.

SAIF contends that claimant was impaired as evidenced by his failure to react to Mr. Bowen yelling and signaling him to move away from the falling tree, by claimant's perception of when events occurred in comparison to his co-worker's testimony, and by the slow manner claimant was driving his Cat when the tree hit him.

Ferguson talked with claimant approximately 15 to 20 minutes before the accident. Although he had not talked to claimant before, he did not notice anything unusual about claimant's speech or appearance. When claimant left the landing area immediately prior to the accident, he was going fast. When Bowen saw claimant, his Cat was barely moving. Claimant testified that the he did not see or hear Bowen, nor did he see the tree until it hit him. This evidence concerning claimant's actions is insufficient, in itself, to establish the requisite causal connection. Grace L. Walker, supra.

Finally, SAIF contends that it had a legitimate doubt about its liability, and therefore, its denials were reasonable. We adopt and affirm the Referee's findings of fact (particularly finding (3)) and conclusion regarding the unreasonableness of SAIF's August 24, 1992 denial. At the time of the denial, SAIF had no evidence to support its assertion that claimant's consumption of marijuana was the major contributing cause of the accident.

The Referee found SAIF's November 2, 1992 course and scope denial unreasonable because there was no evidence at the time of the denial of whether claimant was on or off the skid trail at the time of the accident. We disagree.

The November 2, 1992 denial issued when additional investigation indicated that claimant was acting outside the course and scope of employment when the injury occurred. (Tr. 176, 177). Contrary to the Referee's finding, the denial was not based on whether or not claimant was on or off a marked skid road, but rather based on discussion with employer and co-workers that claimant was in area where he was not supposed to be. (Exs. OC pp. 1, 18, 20; Tr. 165-68, 175). The SAIF claims adjuster also received information from claimant which contradicted information he had received from the employer and co-workers. (Tr. 175)

Because the evidence, available at the time of its denial, showed that claimant may have engaged in misconduct by disregarding the employer's instruction, we find that SAIF's denial on the ground that claimant was acting outside the course and scope of employment was reasonable. Accordingly, SAIF had a legitimate doubt as to its liability for the claim.

Inasmuch as the Referee assessed a single 25 percent penalty for both denials and since we are affirming the Referee's "unreasonable claim" finding regarding one of the denials, the penalty award is likewise affirmed.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and the hearing record), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 18, 1993 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the SAIF Corporation.

Board Member Haynes dissenting.

The majority holds that claimant's injury occurred within the scope and course of employment because his disregard of the employer's instructions and the logging industry standards merely involved a violation of the method of accomplishing his ultimate work rather than a prohibited overstepping of the boundaries defining that work. Because I would hold that not only claimant's consumption of marijuana, but also his violation of the employer's rules and the logging rules, constituted prohibited acts outside the course of employment, I dissent.

The employer has a drug and alcohol policy prohibiting the use of drugs and alcohol on the job. Claimant was aware of that policy. Claimant's consumption of massive amounts of marijuana the night before the accident was a patent disregard of that policy. (As SAIF so aptly states, claimant was "loaded.")

In finding that claimant remained within the course of his employment, the majority relies on Professor Larson's "ultimate work" test. The majority fails to mention the last sentence of that test, which provides:

> "Violations of express prohibitions relating to incidental activities, such as seeking personal comfort, as distinguished from activities contributing directly to the accomplishment of the main job, are an interruption of the course of employment." 1A Larson, Workmen's Compensation Law 6-8, § 31.00 (emphasis added).

For the reasons stated in my dissent in David Bottom, 46 Van Natta 1485 (1994), I continue to believe that consuming mind-altering substances is not a part of claimant's work. Considering the hazardous nature of the work, the employer's drug and alcohol policy clearly manifested its desire that its employees never work while encumbered by drugs or alcohol. The consumption of drugs and alcohol is an incidental activity, akin to seeking personal comfort, as distinguished from activities contributing directly to an employee's work. Accordingly, under the last sentence of section 31.00, I would conclude that claimant's violation of the employer's drug and alcohol policy constituted an interruption of the course of employment and also a prohibited overstepping of the boundaries defining his ultimate work. David Bottom, supra.

Although the majority implies that a drug and alcohol policy is a method based rule, i.e., it deals with the method of how a job is to be performed, claimant also violated other rules that I would find are not method based rules. By violating these rules, claimant overstepped the work that he was to do for the employer.

Here, claimant's misconduct was the prohibited act of leaving the designated skid trails. By contract, the BLM required the employer to mark skid trails and to construct these designated skid trails prior to logging. The skid operator is required to stay within the parameters of the 14 to 16 foot wide designated skid trail to prevent compacting the soil. A few days prior to claimant's accident, the BLM had warned the employer that the skid operators had been leaving the designated skid trails in violation of the logging contract. Further violations could have resulted in a breach of the logging contract.

Pursuant to the BLM warning, the employer instructed claimant and the other skid operator to stay on the designated skid trails. Claimant was not on a designated skid trail when he was injured. Claimant violated not only the employer's instructions but also the BLM contract by leaving the designated skid trails. The violation of the BLM contract involved more than a violation of the method of accomplishing claimant's work, it overstepped the boundaries of the ultimate work to be done. This violation directly impacted not only claimant's ultimate work, but also the employer's, since such a violation could have resulted in loss of the logging contract and thus loss of work. Therefore, I conclude that claimant left the course of his employment when he left the designated skid trail in violation of the BLM contract.

I would also find a causal connection between claimant's misconduct in leaving the designated skid trails and his misconduct by consuming marijuana. The opinions of Dr. Nahas persuade me that claimant's memory, judgment, and performance were impaired by the marijuana he consumed the night before the accident. The majority does not address the likelihood that claimant was off the designated skid trails because he was impaired by the marijuana. Claimant did not see Bowen (who was less than 40 yards away) waving his orange hard hat, screaming and hollering at claimant to get out of the way of the falling tree. Claimant did not see the 140-foot tree falling his direction until it hit him.

The evidence in the record persuades me that claimant deliberately disobeyed the employer's drug policy, and that this misconduct resulted in impaired performance, which caused him to be off the designated skid trails in violation of the employer's instructions and the BLM contract. Claimant's misconduct involved activities outside the course and scope of his employment. Accordingly, I would find claimant's injury not compensable. Therefore, I respectfully dissent.

In the Matter of the Compensation of
KENNETH R. BULLION, Claimant
WCB Case No. 93-05233
ORDER ON RECONSIDERATION
Black, Chapman & Webber, Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer requests reconsideration of that portion of our June 29, 1994 Order on Review that concluded the Referee did not abuse his discretion in refusing to admit a report from the employer's examining physician (Exhibit 12). For the following reasons, we adhere to our prior conclusion.

The employer contends that we failed to address whether claimant established material prejudice as to the timing of the disclosure sufficient to justify excluding the August 17, 1993 report from Dr. Nathan. (Ex. 12). Specifically, the employer argues that the Board failed to make a finding as to whether claimant had established material prejudice resulting from the timing of the disclosure of Exhibit 12.

The employer apparently assumes that the Board analyzes evidentiary rulings de novo. In James D. Brusseau, II, 43 Van Natta 541, 542 (1991), we said that "where disclosure of a document is untimely, OAR 438-07-018(4) allows the Referee discretion to admit or exclude the document. We review the exercise of such discretion only for abuse." (Emphasis added).

In our previous order, we concluded that the employer had not complied with OAR 438-07-015(4) and had offered no excuse for its failure to do so. Under OAR 438-07-018(4), the Referee has discretion to admit untimely disclosed documents, based on a determination of whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs any prejudice to the other party.

It is undisputed that the report was not timely disclosed, as required by OAR 438-07-015. At the hearing, claimant argued that he would be prejudiced by the admission of the report because that would require cross-examination and the opportunity to have the treating physician comment on the report, which would result in a delay of the proceedings. (Tr. 1). The Referee found that there would be material prejudice from the delay and from admitting a report that said the claim was not compensable. (Tr. 30, 35). In the Opinion and Order, the Referee concluded that "claimant has established material prejudice in that there was no prior medical report stating that the claim was not compensable. Employer has no reason for its failure to disclose. Therefore a finding of good cause outweighing the prejudice is not possible." (O & O p. 2).

We conclude that the Referee found that claimant suffered material prejudice from the timing of the disclosure and properly weighed whether there was good cause for the failure to timely disclose that outweighed the prejudice to claimant. As previously noted, we review the Referee's evidentiary rulings only for abuse of discretion. James D. Brusseau, II, supra. We adhere to our prior conclusion that the Referee did not abuse his discretion in refusing to admit Exhibit 12. Because Exhibit 12 has not been admitted, we do not reach the employer's additional request to reconsider the portion of the order regarding compensability.

We withdraw our June 29, 1994 order. On reconsideration, we continue to adhere to the reasoning and conclusions reached in our original order. Accordingly, on reconsideration, as supplemented herein, we republish our June 29, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD A. COLCLASURE, Claimant
WCB Case Nos. 88-15666 & 89-05949
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys

On June 28, 1994, we issued an Order on Remand which: (1) affirmed Referee Leahy's order that found claimant entitled to vocational assistance; (2) affirmed Referee Nichols' order that declined to assess penalties and attorney fees for allegedly unreasonable claim processing; and (3) awarded a $4,000 attorney fee under ORS 656.388(1) for services rendered before the Board and appellate courts. Noting that he has previously been granted a $5,000 attorney fee award by the Supreme Court, claimant seeks modification of our order to award him $1,250 for services performed before the Board on remand (the only services for which he has not previously been granted an attorney fee).

In order to further consider this matter, we withdraw our June 28, 1994 order. The self-insured employer is granted an opportunity to respond. To be considered, the employer's response shall be due within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIRGINIA L. GAMBOA, Claimant
WCB Case No. 93-08512
ORDER ON REVIEW
Susak, Dean, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The self-insured employer requests review of Referee Peterson's order that set aside its denial of claimant's injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

Claimant works for the employer as a "security representative." Her primary job is to patrol the buildings and grounds of the employer. If claimant observes any problems or suspicious activities, she is to report via a two-way radio. It is the employer's policy that the security representatives are to avoid physical and even verbal confrontations. The employer has 31 security representatives who provide 24-hour patrols of the employer's premises. The security representatives wear police-like uniforms. However, they are not armed. Moreover, no prior police experience or training is required or preferred of job candidates, and no police training is offered to the employees. Rather, at all times material, they are instructed that they are not police officers, and their function is to observe and report.

Although physical altercations and verbal disputes have occurred on the employer's premises (e.g., gang fights, family quarrels, disgruntled employees who have been laid off, and one attempted molestation of a jogger), only once did a security representative have physical contact with a person; and in that case, the contact occurred because the employee did not simply observe and report pursuant to established procedures. Once, claimant encountered a man in the ladies' restroom, but no verbal or physical altercation occurred.

Approximately two times in the past four years, a security representative has requested that they be given martial arts training. Both times, the employer denied the requests on the grounds that the employment policy for the position is to avoid physical contacts, because the position does not serve a police function.

In early 1993, Mr. Savage, who does criminal investigation work for the employer, requested that he be allowed to conduct a "self-defense" class for women. Mr. Savage, a former police officer, is in a separate department from claimant, and supervises two investigators. He developed the four-session course years ago when he worked for the Newberg Police Department. The course is designed

for females in general, from 12 years of age to 70. It is geared for the civilian populace (not employment related) and is open to any female in the community. As a goodwill gesture, the employer approved Mr. Savage's request.

The employer paid Mr. Savage to conduct the self-defense classes in the evening. The class was open to all females, including employees and members of the general public. Each participant in the class was charged $3.00 to participate. The employer rented a large meeting area at the Cedar Hills Recreation Center for the purpose of conducting the class. The purpose of the $3.00 charge was to defray the rental costs.

Claimant signed up for the class and paid the $3.00 charge. One of the classes was scheduled for 7:00 p.m. on March 3, 1993. On that day, claimant was scheduled to work her normal shift of 2:30 p.m. to 10:30 p.m. Claimant requested that she be able to leave work to attend the class and return to work afterwards. Claimant's supervisor granted claimant's request; however, claimant was not paid during the time she attended class and took vacation leave for that time period.

Claimant left work prior to the beginning of the class and drove her automobile to the Cedar Hills Recreation Center, which is located a short distance from the employer's premises. Claimant attended the class and intended to return to the employer's premises to complete her work shift. While she was crossing a public street to return to her automobile, claimant was struck by another automobile and sustained significant injuries.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the seven factors of the work relationship test enunciated in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or App (1985), and found that claimant's injuries had a sufficient relationship to work and, therefore, was compensable. We disagree.

In Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994) (a decision issued subsequent to the Referee's order), the Supreme Court explained that there are two elements in determining whether an injury is compensable: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arise out of employment" tests the causal connection between the injury and the employment. Each element is part of a single inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Id. at 366; Rogers v. SAIF, 289 Or 633 (1980).

Seven factors have been identified to determine whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3)whether the risk was an ordinary risk of, and incidental to, the employment: (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed or acquiesced in by the employer; and (7) whether the employee was on a personal mission of her own. Mellis v. McEwen, Hanna, Grisvold, supra. All of the factors may be considered; no one factor is dispositive. Id.

Benefit to the Employer

Claimant's activity of taking the self-defense class did not provide any benefit to the employer. The employer's policy was that security representatives avoid physical confrontations and only observe and report problems or suspicious activities. In light of the employer's policy with regard to the duties of security representatives and how those duties are to be performed, we do not find that claimant's attendance at the class provided benefit to the employer. It provided no more benefit to the employer than did the attendance of women from the community in general.

Activity Contemplated by the Parties

The employer sponsored the class, including renting the recreation center and paying the instructor. In addition, the employer posted flyers advertising the class in the workplace. Finally, claimant was allowed to leave work to attend the class. We conclude that attending the self-defense class was contemplated by the parties.

Ordinary Risk Incidental to Employment

The employer did not require or encourage claimant to attend the class. Moreover, in light of the employer's nonconfrontation policy, we cannot say that claimant's attendance was incidental to her employment. Consequently, we conclude that claimant was not engaged in an activity incidental to employment when she was injured leaving the class.

Payment for the Activity

Claimant was not paid for the time she took off to attend the class.

Activity on the Employer's Premises

Claimant's injury did not take place on the employer's premises, nor did it occur on premises rented by the employer. Rather, she was injured while crossing a public street after leaving the class which was conducted on premises leased by the employer.

Employer Direction or Acquiescence

The employer did not direct claimant to attend the class. However, claimant was allowed to leave her regular work shift to attend the class. Thus, the employer acquiesced to claimant leaving work to attend the class.

Personal Mission

Claimant was not paid to attend the class, but rather used vacation time. The employer did not require claimant to attend the class. Furthermore, we have found that claimant's class attendance did not benefit the employer, particularly in light of its nonconfrontational policy. On this record, we find that claimant was on a personal mission when she was injured.

In combination, the factors preponderate against a finding of a sufficient work connection to establish the compensability of the claim. Claimant was engaged in a personal mission, was not on her employer's premises or premises leased by her employer, was not being paid, and was not engaged in a task that benefited the employer or was incidental to her work. While the activity was contemplated by and acquiesced in by her employer, we find these considerations insufficient to establish the work connectedness of claimant's injury. Accordingly, claimant has not established that she was injured in the course and scope of her employment.

ORDER

The Referee's order dated November 17, 1993 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's award of a $3,000 assessed attorney fee is also reversed.

In the Matter of the Compensation of
DOUGLAS J. LAMBERT, Claimant
WCB Case No. 93-07884
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband, Hall, and Haynes.

Claimant requests review of Referee Neal's order that upheld the insurer's denial of his aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception. Claimant's treating physician, Dr. Rabie, M.D., restricted claimant from work for two days: March 25 and 26, 1993.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's aggravation denial, finding that claimant had proven neither a worsening, nor a loss of earning capacity. We disagree.

In order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds, 106 Or App 687 (1991), rev den 312 Or 150 (1991). The worsening must be established by medical evidence supported by objective findings. ORS 656.273(1). Furthermore, because claimant has received a previous permanent disability award for his injury, he must establish that any worsening is more than a waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8).

Claimant has established that he experienced a temporary worsening of his compensable low back condition. This worsening occurred on March 24, 1993. (Ex. 74). Claimant experienced severe discomfort prompting his treating physician, Dr. Rabie, to restrict him from work on March 25 and 26. (Ex. 76). Moreover, Dr. Rabie explicitly opined that the major contributing cause of claimant's worsening, and the resultant need for "time loss," was his accepted low back condition. (Ex. 75).

The only other physician to examine claimant after his worsening on March 24, 1993, was Dr. Amstutz, M.D. (Ex. 85A). Dr. Amstutz examined claimant on July 23, 1993, and diagnosed claimant's condition as an "exacerbation of [claimant's] previous on-the-job injury." (Ex. 85A-2). Furthermore, while giving no specific dates, Dr. Amstutz noted that "time loss" was authorized. (Ex. 85).

The opinions of Drs. Rabie and Amstutz establish two of the requisite elements for a compensable aggravation claim for an unscheduled permanent disability condition: (1) claimant's compensable condition has worsened since the last award of compensation; and (2) diminished earning capacity (as evidenced by claimant's inability to work for two days).

Because we conclude that claimant has established, by objective medical evidence, that he has experienced a worsening resulting in diminished earning capacity, we address the last element necessary to establish a compensable aggravation. Namely, whether the last award of compensation contemplated future waxing and waning of claimant's compensable low back condition. See 656.273(8); Smith v. SAIF, supra.

When there is medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, supra.

Here, there is no evidence of any predictions of future flare-ups contained in the September 20, 1991 stipulation (which awarded an additional 5 percent unscheduled permanent disability for a total award of 13 percent). (Ex. 52). There is no indication that the stipulation was based on a chronic condition. See Theodore W. Kinder, 46 Van Natta 391, 393 (1994). Furthermore, the medical evidence in existence at the time of the last award of compensation (e.g., chartnotes and job analyses from Drs.

Rabie and Amstutz) does not support a finding that the stipulation "contemplated" future waxing and waning of the low back condition. (Exs. 48, 49, 50). See Debra K. Donovan, 45 Van Natta 1175, 1176-77 (1993); Linda J. Hughes-Smith, 45 Van Natta 827, 828 (1993).

Based on our foregoing reasoning, we concluded that claimant has satisfied his burden of proving a worsening of his compensable low back condition and, consequently, claimant is entitled to have his claim reopened. See ORS 656.273(6).

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing, and on review, concerning the aggravation issue is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and appellate briefs), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated October 13, 1993, is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, payable by the insurer.

Board Member Haynes dissenting.

The Referee found that claimant had not sustained his burden of proving a worsened condition. Specifically, the Referee reasoned that claimant was not less able to work since his last arrangement of compensation on June 25, 1991. Therefore, claimant did not have diminished earning capacity as a result of his increased symptoms. See Smith v. SAIF, supra.

However, the majority accepts claimant's argument that a treating physician's release from work for one or two days demonstrates the requisite diminished earning capacity. I disagree.

Claimant experienced a temporary increase in symptoms that prompted him to see his treating physician, Dr. Rabie. (Ex. 74). Dr. Rabie found no new "neurological deficit," but due to claimant's discomfort, Dr. Rabie kept him off work that day with a release to return to work the following day. Moreover, Dr. Rabie never indicated that claimant was less able to perform modified work in 1993 than he was following his compensable injury in 1990. Nor is there any other medical evidence that indicates claimant was less able to work within the medium work range with a 50-pound weight restriction.

This Board has previously found a treating physician's release from work to be dispositive of diminished earning capacity. See Michael K. Janes, 44 Van Natta 1817 (1992). However, the weight afforded a release to work is dependent on the surrounding circumstances, as is the vast majority of medical evidence. See George W. Hanlon, 45 Van Natta 2403 (1993) (Treating physician's report of increased work restrictions is not dispositive of diminished earning capacity where those limitations are similar to the physical requirements of the job the claimant was performing at the time of the alleged worsening).

Here, claimant testified that he began to experience increased low back symptoms when he exceeded the work restrictions set by Dr. Rabie. (i.e., claimant lifted 90 pounds of concrete despite a 50-pound lift and carry restriction). (Tr. 18). Claimant returned to employment within his original lift and carry restriction. (Tr. 24).

Under these circumstances, the evidence shows that claimant experienced a transient worsening of symptoms due to exceeding his work restrictions. Although claimant suffered no permanent, or even extended, period of disability, the majority finds that a release from work for even one day demonstrates temporary worsening sufficient to establish an aggravation claim. This sort of "de minimis" threshold for loss of earning capacity is contrary to statutory intent. See ORS 656.273(1)(a).

Accordingly, I respectfully dissent.

In the Matter of the Compensation of
DONNA J. LOOK, Claimant
WCB Case No. C4-01448
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
W Todd Westmoreland, Claimant Attorney
R. Kenney Roberts, Defense Attorney

On June 9, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

On July 8, 1994, the Board requested an addendum requiring correction of language typically included in a disputed claim settlement. Specifically, the CDA states:

> "IT IS FURTHER STIPULATED AND AGREED that this settlement shall resolve all issues or claims that were raised or could have been raised as of the date of the approval of this settlement." (P. 4, Ln. 21-24). (Emphasis supplied).

We have previously disapproved a CDA which contained similar language. See Victor F. Lambert, 42 Van Natta 2707 (1990). In Lambert, the proposed agreement stated that the parties agreed that the disposition resolved "all issues currently raised or raisable" concerning "outstanding claims for workers' compensation benefits, whether filed or not." (Emphasis supplied). Furthermore, the Board has disapproved CDA's involving or referring to denied claims. See Donald Rhuman, 45 Van Natta 1493 (1993); Frederick M. Peterson, 43 Van Natta 1067 (1991).

On July 18, 1994, the Board received the self-insured employer's response to our request to correct the above-stated language. The employer submits that such language is used in all settlements, not just in a disputed claim settlement. The employer contends that the language is specifically used in this CDA for the purpose of eliminating a permanent disability issue which is pending pursuant to a filed hearing request.

Notwithstanding the employer's argument, we continue to conclude that the language in the current CDA is language typically found in a Disputed Claim Settlement, and may be construed to refer to claims other than the accepted claim. Although the employer argues that the language is necessary to settle an issue of permanent disability, the parties' CDA specifically provides that permanent disability benefits are being fully released or settled. Pg. 1, Pg. 4.

Additionally, although the employer has expressed concern regarding an existing hearing request on the issue of permanent disability, the Board has no objection to the parties inserting a reference to such a hearing request in the CDA. In any event, whether the hearing request is either expressly or implicitly withdrawn pursuant to the CDA, as a result of the CDA receiving Board approval, a referee will subsequently issue an Order of Dismissal pertaining to a hearing request where issues involving "released benefits" have been settled.

Accordingly, under the circumstances described herein, and because the parties have not submitted an addendum eliminating the specified language, we find that the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2)(b); Victor F. Lambert, supra. Accordingly, we decline to approve the agreement and we therefore return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed dispositions. See OAR 436-60-150(4)(i) and (6)(e).

The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
IRIS S. NORMENT, Claimant
WCB Case Nos. 93-08617 & 93-05498
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Lundeen, et al., Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Kemper National Insurance Companies, on behalf of MTI Inc., requests review of those portions of Referee Crumme's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome; (2) upheld Liberty Northwest Insurance Corporation's denial, on behalf of School Bus Services, for the same condition; and (3) assessed a penalty against Kemper for an allegedly unreasonable denial. On review, the issues are responsibility and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except for fact number 13.

CONCLUSIONS OF LAW AND OPINION

Responsibility

From 1985 through February 1993, claimant worked for Liberty's insured as a bus driver. On March 1, 1993, claimant began working for Kemper's insured as an electronic technician. On March 4, claimant developed numbness and pain in both wrists and arms and, on March 8, sought treatment. Claimant subsequently was diagnosed with bilateral carpal tunnel syndrome.

The Referee first determined that claimant's condition was compensable. Then, relying on the last injurious exposure rule, the Referee concluded that Kemper was responsible for the claim. Kemper disputes only responsibility, contending that responsibility should be assigned to Liberty based on medical evidence that work activities with Liberty's insured was the major contributing cause of claimant's carpal tunnel syndrome.

To begin, we agree with the Referee's application of the last injurious exposure rule. The rule may be invoked if the claimant has worked for more than one employer that could have contributed to an occupational disease; it assigns liability for the disease to the potentially causal employer on the risk at the time of onset of disability. E.g., Bracke v. Baza'r, 293 Or 239, 248 (1982). The claimant need only prove that the disease was caused by employment-related exposure; whether one workplace actually caused the disease is irrelevant. Runft v. SAIF, 303 Or 493, 500 (1987).

Here, because no party challenges the Referee's conclusion that claimant's carpal tunnel syndrome is compensable, the condition has been proved to be work-related. Furthermore, the record shows that claimant's employment at Liberty's insured and Kemper's insured potentially caused his carpal tunnel syndrome. (Exs. 13, 15, 20, 22, 23A, 24). Thus, applicability of the last injurious exposure rule is appropriate. See Bracke v. Baza'r, supra; Runft v. SAIF, supra. Inasmuch as claimant became disabled while working for Kemper's insured, Kemper is responsible for the claim. Id.

Kemper opposes the application of the last injurious exposure rule and assignment of liability solely on the assertion that the record establishes that the major contributing cause of claimant's condition is her work activities as a bus driver with Liberty's insured. Even assuming that Kemper has accurately assessed the medical evidence, we would still apply the same rule, with the same result. As discussed above, invocation of the rule is proper when the disease is proved to be work-related and the claimant has worked for more than one potentially causal employer; because those factors are present in this case, actual causation or apportionment of liability has no relevance. See Runft v. SAIF, supra.

Moreover, Kemper provides no proof that claimant's prior work as a bus driver was the sole cause of her condition or that it was impossible for work at its insured to have caused the disease. Thus, there is no basis for shifting responsibility to Liberty. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374 (1984). Thus, we conclude that the Referee correctly concluded that Kemper is responsible for claimant's carpal tunnel syndrome.

Penalties and Attorney Fees

The Referee assessed a penalty against Kemper on the basis that its denial of compensability was unreasonable. Specifically, the Referee found that, at the time of the issuance of the denial, "all of the expert medical opinion evidence that it had received then indicated that claimant's work had caused [claimant's] condition and that her claim was compensable." We agree with Kemper that a penalty is not warranted.

Whether a denial is unreasonable depends upon whether a carrier as a legitimate doubt regarding its liability, based on the available evidence at the time of denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Continuation of that denial can also become unreasonable if new evidence destroys any legitimate doubt about liability. Id. at 592.

When Kemper issued its denial, there was medical evidence indicating that claimant's bus driving work, rather than employment at Kemper's insured, was the major contributing cause of her carpal tunnel syndrome. (Ex. 13-2). Furthermore, at that time, claimant had filed a claim only against Kemper, alleging that work at its insured had caused her condition. (Ex. 8). Thus, when Kemper issued its denial, Kemper's potential liability was based on an allegation that work activities at its insured were the major contributing cause of claimant's condition. In view of evidence that employment at another carrier's insured was the major contributing cause, we find that Kemper had legitimate doubt regarding its liability.

Furthermore, we find that continuation of the denial was not unreasonable. By filing a claim against Liberty, claimant raised the possibility that the last injurious exposure rule could be invoked. However, notwithstanding the application of the last injurious exposure rule, claimant had the burden of proving that his condition was work-related. We find that medical evidence existing when claimant filed the claim against Liberty indicating that claimant's condition was idiopathic provided Kemper with a legitimate doubt that claimant's carpal tunnel syndrome was work-related. (Ex. 20-3). Additional medical support for Kemper's defense is found in the subsequent opinion of Drs. Watson and Dineen that the major cause was neither the work at Kemper's insured, nor at Liberty's insured. (Ex. 25).

Consequently, we find that Kemper's denial of compensability was not unreasonable and, therefore, claimant is not entitled to the assessment of a penalty. See ORS 656.262(10).

Because compensability was at issue at hearing, and we have de novo review, claimant's compensation remained at risk on review. See Cigna Insurance Companies v. Crawford and Co., 104 Or App 329 (1990). Therefore, claimant's attorney is entitled to an assessed attorney fee for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, to be paid by Kemper. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 22, 1993 is affirmed in part and reversed in part. That portion of the order assessing a penalty against Kemper is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500, payable by Kemper.

In the Matter of the Compensation of
KENNETH F. ROSENBAUM, Claimant
WCB Case No. 93-07194
ORDER ON REVIEW
Myrick, Seagraves, et al., Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee Michael V. Johnson's order that set aside its denial of claimant's seizure disorder claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the following finding: "He was knocked unconscious, though initial hospital documents erroneously reported claimant had not been unconscious." In its place, we provide the following: Initial hospital reports indicated that claimant did not lose consciousness following the accident. Following his release from the hospital, claimant reported to medical providers that he lost consciousness for 15 minutes, with subsequent reports of a loss of consciousness for one hour.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

In his respondent's brief, claimant asserts that SAIF's denial of his seizure disorder constitutes a "back-up" denial. After reviewing claimant's request for hearing and the hearing record, we find no evidence that claimant made such a contention at hearing. The Referee's order also is limited to deciding compensability and does not address whether SAIF issued a "back-up" denial. Therefore, we conclude that claimant did not raise the "back-up" denial issue at hearing, and we decline to address it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Compensability

In 1988, claimant sustained compensable injuries as a result of a motor vehicle accident. Since his accident, claimant has experienced episodes of dizziness and loss of consciousness. The Referee found that claimant had a seizure disorder and that the condition was compensable under either the material or major contributing cause standard. We agree with SAIF that claimant failed to prove the compensability of his condition.

The record contains one medical opinion supporting a causal relationship between claimant's condition and the accident. Dr. Sullivan, claimant's treating neurologist since December 1991, reported that he had "always considered that the major contributing cause of [claimant's] need for treatment of his seizures was the events associated with his truck accident in 1988." (Ex. 25). For the following reasons, we find Dr. Sullivan's opinion to be unreliable.

First, Dr. Sullivan indicated that claimant's seizure condition was causally related to the accident but that claimant's condition also could be due to a sleep disorder, which would not be related to his industrial accident. In view of such statements, we construe Dr. Sullivan's opinion as supporting causation if the correct diagnosis of his condition is seizure disorder. However, whether claimant actually has a seizure disorder, rather than some condition that is not related to the compensable injury, on this record, is very much in doubt. We are unable to conclude that it is more probable than not that claimant has a seizure disorder.

Prior to his treatment with Dr. Sullivan, claimant underwent numerous evaluations concerning his condition. Diagnostic tests, including EEGs, have revealed no abnormalities. (Exs. 1B, 21-3). Moreover, claimant was not diagnosed with a seizure disorder and a vestibular disorder was considered and rejected. (Exs. 3C-4, 9, 10).

Dr. Sullivan is, himself, uncertain about the correct diagnosis. He initially diagnosed only a "possible" seizure disorder. (Ex. 13). Although this diagnosis became more firm after claimant's "spells" decreased with medication, Dr. Sullivan continued to express doubt concerning the correct diagnosis in May 1993 by reporting the possibility that claimant's condition was due to a sleep disorder. (Exs. 15, 20-3, 25). Dr. Sullivan's most recent chartnote stated that claimant continued to be treated for a "suspected post-traumatic seizure disorder." (Ex. 26) (emphasis added).

Furthermore, there is a substantial body of evidence in the record that claimant's symptoms are of a somatic nature. Much of this evidence comes from physicians who were treating claimant or consulting for that purpose. Claimant has undergone a psychological evaluation and a neuropsychological evaluation, both of which indicated that claimant exhibited a personality profile consistent with that of a person who experiences somatic complaints in response to emotional stress. (Exs. 3A, 3C). Dr. Grant, who was claimant's treating physician between October 1988 and July 1991, diagnosed anxiety/adjustment reaction and recommended psychological counseling. (Exs. 3C-2, 6). Dr. Schleuning, who evaluated claimant for a vestibular disorder, noted that claimant's vestibular function study results "could easily be feigned" and that his platform test "was highly abnormal" but "inconsistent with the activity level." (Exs. 8, 10, 11).

In conclusion, we find that the record does not support claimant's assertion that he has a seizure disorder. Dr. Sullivan's stated opinion is qualified, and the tests that he (and SAIF's "in-house" physician, Dr. Mass) recommended as a method to confirm or disprove the evidence of a seizure disorder were not requested by claimant or done. Therefore, having found that Dr. Sullivan's opinion is entitled to little weight, we conclude that claimant failed to prove the compensability of his condition, whether analyzed as a direct or consequential condition of his industrial accident. See ORS 656.005(7)(a), 656.005(7)(a)(A).

ORDER

The Referee's order dated December 1, 1993 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
MARK OSTERMILLER, Claimant
WCB Case No. 93-04010
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Garaventa's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 31, has worked for the employer for about eight years. In 1989, he took a medical leave of absence for reasons unrelated to this claim. Claimant returned to work full time as a vault teller in Eugene. (Tr. 54). In September 1991, he transferred to Portland, where he continued the same work. (Tr. 54). On August 31, 1992, claimant reduced his schedule to three eight-hour days a week and worked as a drive-up or window teller. (Tr. 46, 52, 53, 54, 55).

As a vault teller, claimant was responsible for the cash for the branch during the day's operations. His work activities included lifting and swinging about 16 bags of coins, weighing about 25 pounds apiece, twice a day. Claimant also lifted onto a hand truck coin bags that were filled during the day. He also lifted from ten to thirty night deposit bags weighing from two to ten pounds apiece.

(Tr. 18, 20, 62, 64, 65). While working as a vault teller, a drive-up teller or a window teller, claimant input data into various keyed machines, counted out bills, typed, filled out forms, and tore up forms. As a drive-up teller, he pushed and pulled a transaction drawer in and out. (Tr. 32, 33, 67 68). As a drive-up teller, he completed an average of 250 to 300 transactions a day and occasionally completed 400 transactions a day; as a window or vault teller he completed about 100 to 150 transactions a day. Each transaction required repetitive use of the hands. (Tr. 22, 70, 72 and 74).

Claimant first noticed hand discomfort when working at the Eugene branch, especially after throwing coin bags and typing. (Tr. 35). In August 1992, claimant dropped a coffee pot when his right hand "went limp." (Tr. 35, 57). Claimant initially sought treatment for his hand symptoms on December 23, 1992. (Tr. 35; Ex. 17). On March 15, 1993, claimant underwent a left carpal tunnel release and, on April 5, 1993, a right carpal tunnel release. (Exs. 29 and 32).

On April 5, 1993, the employer issued a denial on the basis that claimant's bilateral carpal tunnel syndrome did not arise out of and in the course and scope of his employment, and that his work activities were not the major contributing cause of his condition. (Ex. 34).

Claimant is five feet eight inches tall and weighs about 275 pounds. He is left hand dominant. (Tr. 38). Claimant has high blood pressure, for which he takes Isoptin. He also takes Nardil, an anti-depressant, Xanax for anxiety, and, since about January 1993, a synthetic hormone supplement for hypothyroidism. (Tr. 41, 42).

In March 1993, claimant experienced water retention, which was eliminated by reducing his hypothyroidism medication. (Tr. 42, Ex. 27).

CONCLUSIONS OF LAW AND OPINION

An occupational disease is any disease or infection arising out of employment which requires medical services or results in disability or death, including any series of traumatic events or occurrences which require medical services or result in physical disability. ORS 656.802(1)(c). Claimant must show that his work activities are the major cause of the disease or worsening of a preexisting disease, which must be established by objective findings. ORS 656.802(2).

Both Dr. Roberts, claimant's attending orthopedic surgeon, and Dr. Button, the employer's medical examiner, agreed that claimant had longstanding bilateral carpal tunnel syndrome that was progressively worsening and required surgical decompression. (Exs. 22 and 25). Thus, the issue before us is whether claimant's condition was caused by his work.

Due to the number of potential causes for claimant's condition, the causation question is medically complex. Resolution of the issue requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find no such reasons.

Three doctors provided medical opinions: Drs. Button, Radecki and Roberts. Dr. Button concluded that claimant's obesity was the cause of his carpal tunnel condition, for the following reasons. First, claimant's job duties were very light and, consistent with that fact, there is no increased incidence of carpal tunnel syndrome in the banking industry. Second, claimant's obesity caused hypertension and cardiac insufficiency. Third, claimant has hypothyroidism. Dr. Button explained that carpal tunnel syndrome is known to occur in conjunction with cardiac insufficiency and the use of arterial shunts in renal patients and in 20 percent of second and third trimester pregnant women who gain weight rapidly. In both of these groups, an increase in the fluid content of the body results in edema and vascular compromise. Dr. Button also noted that hyperthyroidism is generally found in conjunction with a thickening of the carpal lining tissue. Dr. Button thus reasoned that claimant's obesity caused him to develop secondary cardiac insufficiency and hypertension.

We are not persuaded by Dr. Button's opinion. First, he was under the false impression, from viewing a videotape, that claimant's work was very light, and his repetitive activities were not intense.

However, the videotape did not accurately reflect claimant's specific duties as a vault teller or his exceptional speed in performing a window or drive-up teller's duties. Furthermore, the incidence of carpal tunnel in the banking industry is a generality that does not persuasively address the specific duties of claimant's job. See Somers v. SAIF, 77 Or App 259 (1986). Second, claimant has not been diagnosed with cardiac insufficiency. Rather, he is taking medication to control his hypertension so that he will not develop such a condition. Third, claimant's single incident of fluid retention occurred in March 1993, seven months after he noticed worsened hand symptoms, and was a result of the higher than optimal dose of the medication he had been prescribed to control his hyperthyroidism. Once the dose was corrected, claimant no longer retained fluid.

Dr. Radecki concluded that claimant's obesity was the major contributing cause of his carpal tunnel syndrome and that he was predisposed to the condition by his hyperthyroidism. He based his conclusions on medical literature, which he provided. Again, we are not persuaded by his opinion. First, the literature does not indicate that obesity is the cause of carpal tunnel syndrome. Rather, it only shows that there is a statistical correlation between carpal tunnel syndrome and certain other medical conditions. For instance, body mass index is considered to be a "risk factor," i.e., is associated with the slowing of median nerve sensory conduction in industrial workers. (Ex. 41-11). However, this association noted in a group of workers in a longitudinal study does not establish that obesity in the individuals studied, as in claimant, is the cause of carpal tunnel syndrome generally or in this particular case. The studies themselves speak carefully in terms of "association," rather than "causation," and we are not satisfied that a statistical correlation or association is sufficient logically, mathematically, or indeed legally, to establish causation.

Dr. Roberts, claimant's treating physician, opined that the major contributing cause of claimant's bilateral carpal tunnel syndrome was the repetitive use of his hands at work. The record shows that claimant worked as a vault teller beginning in June 1989 in Eugene. (Ex. 8). His daily work as a vault teller included lifting and swinging about 16 bags of coins weighing about 25 pounds apiece twice a day, lifting coin bags that were filled during the day onto a hand truck, and lifting from ten to thirty night deposit bags weighing from two to ten pounds apiece, in addition to inputting data into various keyed machines, counting out bills, typing, filling out forms, and tearing up forms. As a drive-up teller, claimant pushed and pulled a transaction drawer in and out, input data, counted out bills, and filled out forms. In this position, he completed an average of 250 to 300 transactions a day and occasionally completed 400 transactions a day; as a window or vault teller he completed about 100 to 150 transactions a day. Each transaction required rapid, repetitive use of the hands.

On this record, we are more persuaded by the opinion of Dr. Roberts, claimant's treating physician. The other physicians relied on an inaccurate videotape purporting to show claimant's job duties, and they also relied on an inaccurate medical history, as discussed above. Furthermore, they based their analysis of the causation of claimant's condition on general studies of a statistical correlation between certain risk factors and the slowing of median nerve conduction as well as other statistical generalities. We conclude that claimant has proved that his bilateral carpal tunnel condition is compensable. See ORS 656.802(2).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $4,687.50, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief, claimant's counsel's statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 25, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $4,687.50, to be paid by the employer.

In the Matter of the Compensation of
WALTER C. WINDOM, Claimant
WCB Case No. 93-05126
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Crumme's order that: (1) set aside a Director's order which dismissed claimant's request for vocational assistance because claimant's aggravation rights had expired; and (2) directed SAIF to provide vocational assistance as though claimant's aggravation rights had not expired. On review, the issue is vocational assistance. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Dr. Kendrick, claimant's treating surgeon, recommended vocational assistance. At the time of that recommendation, claimant's 5-year aggravation rights under ORS 656.273(4) had expired.

SAIF notified Dr. Kendrick and claimant of claimant's ineligibility for vocational services, stating that such services "cannot be authorized in Own Motion claims." (Exs. 2, 4). Claimant requested Director review of the Notice of Ineligibility.

A Director's order dismissed claimant's request for vocational assistance, because "a Board's Own Motion reopening cannot be used as a basis for potential eligibility for vocational assistance." (Ex. 6). Claimant requested a hearing.

The Referee set aside the Director's order and directed SAIF to provide vocational assistance. In reaching this result, the Referee followed David F. Meissner, 45 Van Natta 249 (1993), which held that claimants are not disqualified from vocational assistance under ORS 656.340 merely because their aggravation rights have expired.

Subsequent to the Referee's order, the court reversed our decision in Meissner. All American Air Freight v. Meissner, 129 Or App 104 (1994). The court reversed per curiam citing Harsh v. Harsco Corporation, 123 Or App 383 (1993), rev den 318 Or 661 (1994), which held that "the only benefits available to a claimant whose aggravation rights have expired are those referred to in ORS 656.278(1)." 123 Or App at 387. Finding no statutory authority for vocational benefits for "Own Motion" claimants, the court upheld the Director's order effectively denying such benefits. Id.

We are constrained to follow the court's holding in Harsh and Meissner. Accordingly, because claimant's claim is in Own Motion status, he is ineligible for vocational assistance and the Referee's order must be reversed.

ORDER

The Referee's order dated September 21, 1993 is reversed. The Director's order dismissing claimant's request for vocational assistance is reinstated and affirmed.

Board Member Gunn specially concurring.

While I do not agree with the ultimate result of this decision, I am constrained by the court's decisions in Harsh and Meissner to agree that claimant is not entitled to vocational assistance. I write this specially concurring opinion to express my doubts concerning the court's reasoning.

In Harsh, the court concluded that claimant was not entitled to vocational assistance because ORS 656.278 did not grant the Board the authority to grant vocational assistance. I have no disagreement with this conclusion. I'm not aware that the Board has ever had authority, under ORS 656.278 or any other statute, to grant vocational services.

ORS 656.340 is the statutory provision that governs entitlement to vocational assistance. Nowhere in that statute does it provide that a worker is not entitled to vocational assistance merely because his aggravation rights have expired. It is this statute, and the attendant administrative rules promulgated by the Director, that the Board addressed in David F. Meissner, 45 Van Natta 249 (1993). Despite this, the court reversed the Board's decision with only a citation to the Harsh case which, as noted above, did not even address the relevant question.

The court's cursory treatment of this issue seems particularly suprising when one of the express purposes of the Workers' Compensation act is to return injured worker to a self-sufficient status quickly and "to the greatest extent practicable." ORS 656.012(2)(c). The court's decisions in both Harsh and Meissner seem to be at odds with this purpose and neither decision gives any reasoning as to how ORS 656.340 operates to create an exception to this purpose by limiting vocational assistance to workers whose aggravation rights have not expired. I hope that in the future the court takes it upon itself to explain its decision in light of the relevant statutory authority.

In the Matter of the Compensation of
DALE A. BOWKER, Claimant
WCB Case Nos. 92-14930 & 92-10985
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Rasmussen & Henry, Defense Attorneys
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Hall, Westerband and Haynes.

Central Coast Concepts, a noncomplying employer (the NCE), requests review of those portions of Referee Holtan's order that: (1) denied the NCE's motion to dismiss claimant's request for hearing against it on the ground that claimant had not appealed the NCE's denial within 90 days; and (2) set aside SAIF's denial (on behalf of the NCE) of claimant's L4-5 disc herniation injury claim. Claimant has moved to dismiss the NCE's request for review on the ground that the NCE has no standing to appeal the Referee's order. On review, the issues are standing, jurisdiction, credibility and compensability. We deny the motion to dismiss and affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the following supplementation.

On March 31, 1992, claimant sought treatment from Dr. Gates, D.C. At that time, claimant did not report the incident in which his co-worker dropped a wood beam that he and claimant were carrying.

CONCLUSIONS OF LAW AND OPINION

The NCE's Standing to Request Review of Referee's Order

Claimant moves to dismiss the NCE's request for review on the ground that, because the claim had been referred to SAIF several days before the NCE filed its request for hearing, and because the NCE did not contest subjectivity, pursuant to ORS 656.054, the NCE should not be considered a party, and thus, has no standing to appeal the Referee's order. We disagree.

ORS 656.054(1) provides that, after the Director refers the claim of an injured worker of a noncomplying employer to SAIF, the Director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim. The noncomplying employer then may request a hearing to object to the claim at any time within which the claim may be accepted or denied as provided in ORS 656.262. ORS 656.054(1).

Here, the NCE timely requested a hearing to contest the compensability of claimant's back condition. (See Ex. 17A). Because nothing in the text or context of ORS 656.054 reveals a legislative intent to curtail the appellate rights of noncomplying employers who timely object to a claimant's workers' compensation claim or to SAIF's claims processing decisions regarding their employees, we conclude that the NCE has standing to appeal the Referee's order to this Board.

Furthermore, the parties agree that the NCE is a noncomplying employer. Because an "employer" is a "party", ORS 656.005(20), the NCE is entitled to challenge ensuing claims processing decisions arising from the "noncomplying" determination. Ronnie D. Maynard, 45 Van Natta 1803 (1993) (noncomplying employer has standing to challenge order on reconsideration awarding temporary total disability benefits); see Astleford v. SAIF, 319 Or 225 (1994) (statutory definition of "party" in ORS 656.005(20) applies to ORS 656.289(4), and includes noncomplying employers). To hold otherwise would prevent the NCE from contesting decisions for which it would be held responsible for claim costs. Ronnie D. Maynard, supra.; see ORS 656.054(3). For this additional reason, we hold that the NCE has standing to request review of the Referee's decision in this case and we deny claimant's motion to dismiss.

Timeliness of Claimant's Request for Hearing Regarding the NCE's "Denial"

The NCE argues that, because claimant failed to timely appeal its August 7, 1992 "denial," the Referee should have dismissed claimant's request for hearing as to the NCE. We disagree.

The document that the NCE characterizes as a "denial" is actually its request for hearing. (Ex. 17A). The request states, in part, that the NCE "requests a hearing denying compensability of an alleged accident of March 26, 1992 * * *" involving claimant. (Id. at 1). The Referee agreed that the request for hearing was a denial. (Tr. 7). Claimant argues to the contrary.

We conclude that we need not resolve that issue because, as the statutory processor for the NCE under ORS 656.054, only SAIF had the authority to issue a claim denial. Clark v. Linn, 98 Or App 393, 396-97 (1989); Elias S. Jones, 45 Van Natta 1579 (1993). Therefore, even assuming that the NCE's request for hearing constituted a denial, the "denial" was issued without statutory authority and, therefore, was invalid. Elias S. Jones, supra. Therefore, we conclude that claimant was under no obligation to request a hearing regarding the NCE's "denial" and we affirm the Referee's denial of the NCE's motion to dismiss.

Credibility

We adopt and affirm the Referee's credibility findings.

Compensability

We adopt and affirm the Referee's conclusions regarding compensability.

Claimant is entitled to an assessed attorney fee for services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by SAIF on behalf of the NCE. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and the record), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated October 15, 1993 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the SAIF Corporation, on behalf of Central Coast Concepts.

Board Member Haynes concurring in part and dissenting in part.

The majority concludes that the noncomplying employer (NCE) has standing to request review of the Referee's order and that claimant was under no obligation to request a hearing regarding the NCE's "denial." I agree. My disagreement is with the majority's decision to adopt and affirm the Referee's credibility findings and conclusions regarding compensability.

Before I proceed, I bring to the reader's attention claimant's burden of proof. Claimant must establish, by a preponderance of the evidence, that his work activities were a material contributing cause of his back condition. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991); see ORS 656.266. On this record, I conclude that the evidence is simply too equivocal to meet that standard.

First, I disagree with two of the Board's credibility findings. The Board adopts the Referee's findings that Scott Basurto (Basurto), the NCE, and one of the NCE's witnesses, Ben Pollock (Pollock), were not credible witnesses. Although the Referee's findings were based, in part, on demeanor, my review of the record convinces me that we should reevaluate the Referee's credibility findings regarding Basurto and Pollock de novo. See Francisco Ochoa, 45 Van Natta 1525, 1526 (1993) (Board authorized, pursuant to its de novo review authority, to reconsider referee's demeanor-based credibility findings).

Basurto's testimony is somewhat vague with respect to the events surrounding this matter. However, I am not convinced that his testimony was untruthful. Rather, I glean from the record that Basurto was both frightened and angry about the possibility for being held responsible for claimant's back condition. In the absence of any specific findings regarding Basurto's demeanor, that is not enough to persuade me that his testimony should be discredited. Therefore, based on my review of the record, I would find that Basurto was a credible witness.

I reach the same conclusion regarding Pollock. He recounted a conversation in which claimant allegedly admitted that he had injured his back while motorcycling. Pollock testified that he then told claimant to file a fraudulent workers' compensation claim. I find the latter testimony a statement against interest sufficient to support the reliability and veracity of Pollock's testimony. See OEC 804(3)(c) (unavailable witness' statement against pecuniary or proprietary interest admissible). For that reason, and because I have found nothing else in the record to impeach his testimony, I would also find that Pollock was a credible witness.

Having concluded that both Basurto and Pollock were credible witnesses, the next task is to ascertain whether claimant has established, by a preponderance of the evidence, that his claim is compensable. For the reasons set forth below, I conclude that the answer that question is "no."

First, there is considerable doubt about when claimant injured his back. Claimant testified that he injured his back during an on-the-job incident in which a co-worker dropped his end of a large wood beam that he and claimant had been carrying (the beam incident). The weekend after the incident, claimant went off-road motorcycling. Claimant's witnesses testified that he sustained no injuries during that excursion. The NCE's witnesses testified to the contrary. Specifically, Pollock testified that both claimant and claimant's wife said that claimant had hurt himself motorcycling. (Tr. 135, 138). Basurto and his girlfriend testified to the same. (Tr. 62, 142). In fact, Basurto testified that claimant told him that he had had a "big" crash while motorcycling. (See Tr. 62).

In light of this testimony, all of which comes from apparently credible witnesses, I am unable to say that the evidence preponderates that claimant injured his back at work; rather, there appears to be a substantial likelihood that claimant injured his back while motorcycling. On that ground alone, I would conclude that claimant has failed to establish the compensability of his back condition.

I also have serious doubts about the medical evidence in this case. Claimant relies on the reports of Drs. Nelson, Hacker, Coletti and Mendius. For the following reasons, I find those reports seriously flawed.

Claimant maintains that he hurt his back during the beam incident. Yet, claimant did not tell his original caregiver, Dr. Paige, chiropractor, about that incident. (See Exs. 1, 2). Two weeks after the incident, claimant saw Dr. Nelson, osteopath, and reported that that he had injured his back while lifting cement at work; he also reported that he had been motorcycling. (Ex. 3-1, -2). The beam incident was not mentioned in the medical reports until claimant's back condition worsened and he saw Dr. Hacker, neurosurgeon, almost two months after the beam incident. (Ex. 5-1). Claimant subsequently "corrected" the medical history he had given to Dr. Nelson when he was examined on the SAIF Corporation's behalf by Dr. Coletti, orthopedic surgeon, and Dr. Mendius, neurologist. Instead of being injured while lifting cement, as he had told Dr. Nelson, claimant reported to Coletti and Mendius that he had injured his back while lifting a wood beam. (Ex. 20-1).

I find that the delay in reporting the beam incident to a medical professional[1] and the inconsistent histories given to claimant's caregivers and examining physicians cast doubt on claimant's credibility and the histories regarding his back injury. See Pauline Taylor, 45 Van Natta 2222 (1993) (inconsistencies in record supported conclusion that claimant was not credible). It goes without saying that a medical report is only as valuable as the history on which it relies is accurate. See Marchia T. Galicia, 46 Van Natta 542, 5643 (1994). Because I find claimant's histories unreliable, I also find that the reports that are based on those histories, including those on which claimant relies, lack persuasive force. Id.

Finally, I find that the reports of Dr. Hacker and Drs. Colleti and Mendius are flawed because they fail to mention claimant's motorcyling activity. Because there is no indication that they were aware of that activity, those physicians were precluded from considering whether motorcycling could have contributed to claimant's back condition. Pamela A. Burt, 46 Van Natta 415 (1994).

For these additional reasons, I conclude that claimant has failed to establish, by a preponderance of the evidence, the compensability of his back condition. Therefore, I respectfully dissent.

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[1] I am not persuaded by claimant's explanation that he delayed reporting the beam incident to his caregivers out of an altruistic desire to protect the NCE.

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
ORDER ON REMAND
Craine & Love, Claimant Attorneys
Pamela A. Schultz, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). In our prior order in Arlene J. Koitzsch, 44 Van Natta 136, on recon 44 Van Natta 776, recon den 44 Van Natta 829, recon den 44 Van Natta 2067 (1992), we declined to increase a referee's scheduled permanent disability award for loss of use or function of claimant's right forearm. In reaching our conclusion, we used impairment findings from a carrier-referred examining physician "for purposes of supporting or impeaching the opinion and ratings offered by [claimant's physician]." The court reversed our order, reasoning that our consideration of the examining physician's findings, even for impeachment purposes, defeated the objective of ORS 656.245(3)(b)(B) to permit only attending physicians to make findings regarding impairment. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A May 4, 1990 Notice of Closure awarded claimant no permanent disability.[1] Relying in part on the impairment findings of an examining physician, the Referee awarded claimant 34 percent (51 degrees) scheduled permanent disability for loss of use or function of the right forearm. Claimant requested Board review seeking an increased award.

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[1] Claimant did not become medically stationary until April 18, 1990. Therefore, although amended ORS 656.245 applies to her claim, the amendments pertaining to the mandatory reconsideration process do not. See Or Laws 1990 (Special Session), chapter 2, §54(3). Thus, claimant was not required to seek reconsideration prior to requesting a hearing on the notice of Closure.

On review of the Referee's order, we initially remanded to the Referee to determine whether Dr. Johnson, claimant's physician who practiced medicine in Washington, was an attending physician under ORS 656.005(12)(b)(A). 44 Van Natta 136 (1992). Claimant sought reconsideration, contending that a medical doctor practicing in and licensed under the laws of another state was included within the definition of "attending physician" under OAR 436-10-005(1)(b).

On reconsideration, we found it unnecessary to remand. 44 Van Natta 776 (1992). We reasoned that even if Dr. Johnson was an "attending physician," his impairment findings were not persuasive evidence concerning claimant's permanent impairment. Specifically, we found Dr. Johnson's findings conclusory, inconsistent with his prior opinion, and not in accordance with the Director's disability rating standards. Based on this reasoning, we declined to award claimant additional scheduled permanent disability. In reaching our conclusion that Dr. Johnson's findings were unpersuasive, we relied on impairment findings from an examining physician "for purposes of supporting or impeaching the opinion and ratings offered by Dr. Johnson."

Noting that ORS 656.245(3)(b)(B) does not make a distinction between offering an examiner's impairment findings for impeachment or proof purposes, the court held that, even for impeachment purposes, such findings were nonetheless impairment findings for the purpose of evaluating the worker's disability. Koitzsch v. Liberty Northwest Ins. Corp., supra. Concluding that the legislature intended to permit only the attending physician to make such findings, the court held that we violated ORS 656.245(3)(b)(B) by receiving and considering the findings of an independent medical examiner. The court has remanded for reconsideration. We proceed with our reconsideration.

The crux of this dispute is whether, under ORS 656.005(12)(b)(A), Dr. Johnson's findings may be considered in determining the extent of claimant's permanent disability. In construing ORS 656.005(12)(a)(A), we first examine the text and context of the pertinent statute. If the text and context are ambiguous, we look to the legislative history. Finally, if those avenues of inquiry do not answer the question, we look to "other aids." Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993).

We begin our analysis by examining the text and context of the statute. In 1990, the legislature added additional language to the definition of "attending physician." ORS 656.005(12)(b) provides:

> "(b) 'Attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury and who is:
>
> "(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners of the State of Oregon or a board certified oral surgeon licensed by the Oregon Board of Dentistry."

ORS 656.005(12)(b)(A) unambiguously requires that, in order to be an attending physician, one must be a medical doctor or doctor of osteopathy licensed by the Board of Medical Examiners of the State of Oregon, or a board certified oral surgeon licensed by the Oregon Board of Dentistry. The statute leaves no room for interpretation, and we are unable to conclude that the statute is ambiguous (which would allow us to resort to legislative history to determine the legislature's intent in enacting the statute).

We acknowledge that the appellate courts have declined to interpret then-existing statutes in a manner that precluded a worker from obtaining an "out-of-state" physician. See Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985) (ORS 656.245 did not permit a workers' compensation carrier to deny payment for treatment by all out-of-state chiropractors); Safeway Stores v. Dupape, 106 Or App 126 (1991) (Employers have only a limited right to veto a claimant's choice of an out-of-state physician and Board could require the the reason for the veto be related to a concern that the out-of-state doctor will not comply with Oregon's workers' compensation reporting requirements or other cognizable purposes of the statute or rules). Nevertheless, those appellate forums were not confronted with ORS 656.005(12)(b)(A), which was adopted subsequent to those decisions. The aforementioned statute clearly and unequivocally requires that an attending physician be licensed to practice in Oregon.

The dissent accurately notes that the 1990 legislature was primarily concerned with the status of a chiropractor as an "attending physician." Nonetheless, the statute, as it currently exists, does more than exclude chiropractors from the definition of "attending physician"; it expressly limits attending physicians to medical doctors, doctors of osteopathy and oral surgeons who are licensed with their respective Boards in the State of Oregon. Considering the clarity of that statutory provision, we are unable to resort to the legislative history to assist us in its interpretation.

If it was the intention of the legislature to permit a physician who is not licensed to practice in Oregon to serve as an "attending physician" then ORS 656.005(12)(b)(A) must be amended to so provide. Barring such an amendment or the issuance of an applicable court decision, we are unable to interpret the statute to include an "out-of-state" physician as an "attending physician."[2]

The record as presently developed indicates that Dr. Johnson is a physician in the State of Washington. (The letterhead on Dr. Johnson's reports carries a Washington address). (Exs. 16, 21 & 22). In light of such circumstances, the current record does not support a finding that Dr. Johnson is licensed to practice medicine in the State of Oregon. Based on the foregoing reasoning, we conclude that Dr. Johnson, a Washington physician, does not qualify, pursuant to ORS 656.005(12)(b)(A), as claimant's attending physician.

With the exception of a medical arbiter, findings concerning the worker's impairment can be made only by the the attending physician at the time of claim closure. See ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1991). Here, no medical arbiter was appointed and there are no findings from an attending physician which would support an award of permanent disability. Under such circumstances, claimant has not established entitlement to a permanent disability award. However, inasmuch as the insurer has not sought a reduction, we do not disturb the Referee's scheduled permanent disability award of 34 percent (51 degrees) for loss of use or function of the right forearm. Daniel M. Alire, 41 Van Natta 752, 759 (1989).

Accordingly, on reconsideration of our prior orders, the Referee's order dated March 11, 1991 is affirmed.

IT IS SO ORDERED.

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[2] We are aware that OAR 436-10-005(1)(b) includes in the definition of "attending physician" a medical doctor, doctor of osteopathy or oral surgeon practicing in and licensed under the laws of another state; we likewise note that other administrative rules contemplate that out-of-state physicians will treat injured Oregon workers. However, an agency may not alter, amend, enlarge or limit the terms of an applicable statute by rule. Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325, 328 (1992), citing Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988). Thus, to the extent that these administrative rules are inconsistent with the definition of "attending physician" found in ORS 656.005(12)(b)(A), they are without effect.

Board Member Gunn dissenting.

ORS 656.005(12)(b)(A) appears to limit attending physicians to physicians licensed in Oregon. However, even prior to the 1990 legislative changes, the term "doctor or physician" was defined by statute as "a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate." Former ORS 656.005(13) (Emphasis added). The definition of "attending physician," prior to the 1990 amendments, was a "doctor or physician who is primarily responsible for the treatment of a worker's compensable injury." Id. Thus, in order to be an attending physician under former ORS 656.005(13), one had to be a "doctor or physician" as those terms were defined in the statute, (i.e., one had to be licensed in Oregon in one or more of the healing arts). In addition, both the former and current versions of ORS 656.245(3) limit a worker's choice of attending physician to a doctor or physician "within the State of Oregon."

In spite of these apparent statutory limitations, the appellate courts have consistently held that an insurer's right to object to a claimant's choice of an out-of-state physician is limited. Reynaga v. Northwest Farm Bureau, supra at 262; Safeway Stores v. Dupape, supra at 129-130 (1991); Day v. S & S Pizza Co., 77 Or App 711, 716 (1986).

In Reynaga, the Supreme Court held that ORS 656.245 did not permit an insurer to deny payment for treatment by out-of-state chiropractors. Although the Court acknowledged that the asserted state interest in guaranteeing full cooperation of doctors had some merit, the Court concluded that this interest would be satisfied by granting insurers a right to veto individual doctors who have demonstrated that they are unlikely to cooperate with reporting requirements. In Dupape, the Court of Appeals held that the Board was entitled to require that the employer state a reason for its objection to an out-of-state physician and to require that the reason be related to a concern that the physician would not comply with Oregon's reporting requirements or other cognizable purposes of the statute or rules. Neither holding concluded that the claimants were precluded from receiving treatment from out-of-state physicians, notwithstanding the existing statute which appeared to limit an attending physician to an "in state" doctor.

In addition, OAR 436-10-005(1)(b) includes in the definition of "attending physician" a medical doctor, doctor of osteopathy or oral surgeon practicing in and licensed under the laws of another state. Finally, I note that OAR 436-10-050(6) allows an insurer to object to an out-of-state medical service provider if that provider does not comply with the Director's rules. That rule provides, in pertinent part:

> "When the worker chooses a medical service provider whose practice is located outside the state of Oregon and the provider does not comply with these rules, the insurer may object to the worker's choice and select the medical service provider. When an insurer objects to an injured worker's choice of physician, the insurer shall notify the worker and the provider that payment for services rendered by that provider after the date of notification shall not be reimbursable."

The Reynaga Court found that, although ORS 656.245(3) allowed the worker to choose an attending physician "within the State of Oregon," the statute was silent with regard to whether a worker could choose a physician outside the state. 300 Or at 259. Therefore, the Court attempted to determine the legislative intent, in construing such silence. Id. ORS 656.005(12)(a)(A) is similarly silent and ambiguous concerning whether an attending physician may be outside the state. Accordingly, it is appropriate to look to the legislative history for guidance regarding the legislature's intent.

The legislative history behind ORS 656.005(12)(b)(A) reveals an intent to limit attending physicians to medical doctors, osteopaths and oral surgeons, rather than to prevent claimants from choosing attending physicians from out-of-state. For example, the initial draft of the 1990 amendments completely excluded chiropractors and other health professionals who were not medical doctors, osteopaths or oral surgeons from serving as attending physicians (the language was later changed to allow chiropractors to serve as attending physicians for 30 days or 12 visits, whichever first occurs).

The statements of legislators and testimony before the committee also indicates that the definition of attending physician was changed to exclude certain specialties from serving as attending physicians. For example, Senator Grensky explained that the Mahonia Hall group chose medical doctors to act as attending physicians since they were trained in all disciplines and could act as "gatekeepers." Joint Comm. May 4, tape 19, side B. Similarly, Mr. Redman testified that medical doctors and osteopathic physicians would provide checks and balances needed for physicians who could not serve as attending physicians. Joint Comm. May 3, tape 2, Side A.

Given the holdings of Reynaga and Dupape, as well as the legislative history, I disagree with the majority and would hold that an out-of-state physician may be an attending physician as long as that physician meets the other criteria set out in ORS 656.005(12)(b) and OAR 436-10-005(1). Based upon those court holdings and the applicable statutes and administrative rules, I would also conclude that, notwithstanding the language of ORS 656.005(12)(a)(A), a claimant may receive medical treatment from an out-of-state physician, subject to the insurer's veto where there is a concern that the physician will not comply with the reporting requirements. However, if an insurer wishes to object to the

claimant's choice of an out-of-state attending physician, it should do so at the time medical services are being provided rather than at claim closure.[1]

Thus, I would conclude that an out-of-state physician may be an "attending physician" if the out-of-state physician is a medical doctor, doctor of osteopathy or oral surgeon practicing in and licensed under the laws of another state.[2] ORS 656.005(12); OAR 436-10-005(1). Accordingly, because I conclude that Dr. Johnson, a medical doctor, qualifies as claimant's attending physician under ORS 656.005(12)(b) and ORS 656.245(3)(b)(B), I respectfully dissent.

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[1] Dr. Johnson began treating claimant for her carpal tunnel condition in 1988 and continued to treat claimant throughout the claim with no objection from the insurer. In fact, it was not until Board review that objections were raised to Dr. Johnson on the basis that he did not qualify as claimant's attending physician. In Sandra L. Masters, 44 Van Natta 1870 (1992), we held that a carrier was not entitled to unilaterally terminate the claimant's temporary disability on the basis that the physician who had previously authorized time loss was no longer an "attending physician" as a result of the 1990 statutory amendments. In reaching our decision in Masters, we relied on a Department Bulletin which required 30 days written notice to a claimant before any benefits could be terminated as a result of the changes in the attending physician definition. Here, as in Masters, no notice was given to claimant that, as a result of the statutory changes, her physician would no longer be able authorize time loss or rate her permanent disability. Under the circumstances, the insurer should not be allowed to raise its objections to Dr. Johnson, with no prior notice to claimant, at such a late point in the claim. In this case, if the insurer's objections were allowed, no physician would be qualified to rate the extent of claimant's permanent disability. Such an outcome would not serve the interests of substantial justice.

[2] OAR 436-10-005(1)(d) also allows a chiropractic physician practicing and licensed under the laws of another state to be an attending physician, "[f]or a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits during that 30 day period, whichever first occurs * * *."

July 29, 1994 Cite as 46 Van Natta 1567 (1994)

In the Matter of the Compensation of
KEITH W. MILES, JR., Claimant
WCB Case No. 90-13770
CORRECTED ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Pamela A. Schultz, Defense Attorney

It has come to our attention that our July 26, 1994 Order on Review contained some clerical errors. Specifically, in the opening paragraph of our order we mischaracterized claimant's permanent disability awards. In the interests of clarifying these mischaracterizations, we replace the opening paragraph with the following paragraph.

Claimant requests review of those portions of Referee Spangler's order that: (1) upheld the insurer's denial of claimant's consequential psychological condition; (2) affirmed a Determination Order which awarded 30 percent (45 degrees) scheduled permanent disability and 26 percent (83.2 degrees) unscheduled permanent disability; and (3) authorized the insurer to offset $7,340.37 in overpaid temporary disability against a $3,162.34 award of scheduled permanent disability which was previously awarded, but not paid. The insurer cross-requests review, contending that the Referee erred in concluding that claimant's total awards to date in the claim are 48 percent scheduled permanent disability for his left leg and 26 percent unscheduled permanent disability for his back. On review, the issues are compensability, extent of unscheduled permanent disability and offset.

Accordingly, we withdraw our July 26, 1994 order. On reconsideration, as corrected herein, we republish our July 26, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWIN W. PEARLE II, Claimant
WCB Case No. 93-07059
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Referee McWilliams' order which upheld the insurer's denial of an aggravation claim for his low back condition. On review, the issues are res judicata and aggravation.

We adopt and affirm the Referee's order, with the following supplementation.

We briefly summarize the pertinent facts. Claimant sustained a low back injury in October 1988, which the insurer accepted as a low back sprain and left sciatica. The claim was closed in January 1989 with no permanent disability.

In 1990, claimant filed an aggravation claim, complaining of severe, left-sided low back pain with radiation into the left leg, with no new injury. The Board upheld the insurer's denial, finding that claimant failed to prove a material causal relationship between the original injury and his worsened condition. (Ex. 20). The Board's decision was affirmed on appeal. (Exs. 24, 30, 32). See Edwin W. Pearle II, 44 Van Natta 42, aff'd mem Pearle v. Liberty Northwest Ins. Corp., 117 Or App 268 (1992), rev den 316 Or 142 (1993).

The current aggravation claim arises out of claimant's complaints of increased low back pain with numbness and tingling radiating into the left leg, beginning in September 1992. Claimant again reported no new injury. This time claimant's left ankle jerk reflex was absent, a finding that both his treating physician and the examining physicians considered objective evidence of a worsening. (See Exs. 31, 35).

The Referee upheld the insurer's current aggravation denial, finding that the medical evidence failed to establish the requisite material causal relationship between the original injury and the current worsened condition. In doing so, the Referee held that the current aggravation claim is not barred by prior litigation of the 1990 aggravation claim. The Referee reasoned, however, that because the medical evidence failed to clearly delineate the relationship between claimant's current worsening, the accepted condition, and the intervening noncompensable condition, claimant failed to prove a material causal relationship between the current condition and the original injury. We agree with the Referee's reasoning and conclusion that the current aggravation claim is not compensable, and we offer the following supplementation.

In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). In other words, an aggravation has two components: causation and worsening. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992), aff'd by equally divided court Fitzpatrick v. Beaverton Welding, 127 Or App 560 (1994). Both components must be established in order to prove a compensable claim.

Here, claimant previously alleged an aggravation of his low back condition in 1990, but that aggravation claim was found not compensable. The insurer contends that principles of res judicata bar the present claim, while claimant contends that res judicata does not apply.

Res judicata, or "preclusion by former adjudication," precludes relitigation of claims and issues that were previously adjudicated. Drews v. EBI Companies, 310 Or 134, 139 (1990); North Clackamas School Dist. v. White, 305 Or 48, mod 305 Or 468 (1988). The term comprises two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation of a subject issue only if that issue was actually litigated and determined in a setting where the determination of that issue was essential to the final decision reached. White, supra. Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den 289 Or 337 (1980). Claim preclusion does not require actual litigation, but it does require the opportunity to litigate, whether or not used. Drews, supra.

Here, we agree with the Referee's determination that claimant's current aggravation claim is not barred by claim preclusion, because the current (1993) aggravation claim, which is based on claimant's need for treatment beginning in 1992, could not have been alleged or litigated under the operative facts of the 1990 aggravation claim.

However, our determination that claim preclusion does not bar this claim does not dispose of the res judicata argument. As noted above, an aggravation has two components: causation and worsening. We next consider whether issue preclusion bars relitigation of either issue, or component, of claimant's current aggravation claim. We begin by determining whether the prior litigation bars relitigation of the causation issue of the current aggravation claim.

Under the res judicata doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined by a valid final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. Drews, supra, 310 Or at 139-40; White, supra, 305 Or at 53.

Here, the parties are the same as in the prior litigation. The prior litigation culminated in a valid final judgment when claimant exhausted appeals of the Board's 1992 Order on Review. The remaining questions are whether the causation issue in the current case is actually the same as the one previously adjudicated and, if so, whether determination of that issue was essential to the earlier judgment.

Claimant's condition in 1990 was diagnosed as recurrent low back strain with left sciatica and left sacroiliitis. (Ex. 6). An MRI in August 1990 revealed L5-S1 spinal stenosis associated with a small central disc herniation. (Ex. 8). Subsequently, Dr. Mentzer diagnosed "persistent low back pain; suspect lumbosacral disk disease vs. chronic low back strain." (Ex. 10-1). Dr. Kitchel, consulting orthopedist, opined that claimant's current back and leg pain was caused in major part by the original 1988 injury, based on claimant's history and Dr. Mentzer's chart notes. (Ex. 11).

The Board, in considering the compensability of claimant's 1990 aggravation claim, found that claimant failed to establish even a material causal relationship between his then-current condition and the original injury. The Board concluded, based on its causation finding, that claimant's 1990 aggravation claim was not compensable. (Ex. 20). Thus, we conclude that the determination of causal relationship was essential to the earlier judgment.

Whether the causation issue previously litigated is the same as the causation issue in the present case depends on whether claimant's condition has changed in the interim. See Liberty Northwest Insurance Corporation v. Bird, 99 Or App 560, 564 (1989); Dean L. Watkins, 44 Van Natta 1003, 1004-05 (1992) (where prior litigation determined claimant's condition was unrelated to compensable injury, "issue preclusion" bars current claim unless claimant proves current condition is different from earlier condition found not compensable).

When claimant returned to Dr. Mentzer for treatment in September 1992, he complained of worsened low back pain with no reinjury, noting that the pain had never really left him. (Ex. 23-1). Dr. Mentzer found increased low back pain with pain, numbness and tingling in the left leg. Dr. Mentzer diagnosed "chronic low back strain with left sciatica, aggravated." (Ex. 23-2). Claimant returned with increased symptoms in January 1993 when Dr. Mentzer diagnosed chronic persistent low back strain with left sacroiliitis and left sciatica. (Ex. 25). Dr. Mentzer noted that claimant continued to have "rather severe low back pain unrelated to any new injury" since his claim was closed in January 1989. (Ex. 26).

Dr. Baker, orthopedist, and Dr. Brooks, neurologist, examined claimant in April 1993. They opined that claimant's current condition represented a natural and expected waxing of symptoms of his low back condition. (Ex. 31-4).

Based on these medical reports, we find that claimant's current low back condition is the same condition that was litigated under the 1990 aggravation claim. While claimant may have sustained a symptomatic worsening in 1992, we find that the underlying low back condition is the same condition that was litigated previously. On the evidence in this record, we are unable to conclude that claimant's condition has changed since the prior litigation.

Because the prior litigation established that claimant's then-current low back condition was not even materially related to his original 1988 injury, and since we find that claimant's current low back condition is the same condition that was previously litigated, we find that the causation issue in the current aggravation claim is precluded by the prior litigation. See Dean L. Watkins, supra. In other words, claimant is precluded from relitigating the issue of a causal relationship between the original injury and his current low back condition, where the evidence fails to establish that his current low back condition is different from the condition previously determined to be unrelated to the original injury. Accordingly, we hold that claimant has failed to establish the compensability of his current aggravation claim.

ORDER

The Referee's order dated October 26, 1993 is affirmed.

Board Member Gunn specially concurring.

I disagreed with the majority in the previous case. See Edwin W. Pearle II, supra, 44 Van Natta at 43. The Court of Appeals has apparently concluded that a law degree may be substituted for a medical degree, at least insofar as the Board members in the majority were able to diagnose that claimant's medical condition did not relate to the previous injury. See Pearle v. Liberty Northwest Ins. Corp., 117 Or App 268 (1992), rev den 316 Or 142 (1993). I have not been persuaded by the passage of time that the majority's conclusion was correct, and pontification by the Court of Appeals does not diminish my belief that the majority was incorrect. But that case is over. To retry it here again seems a waste of good time and legal talent.

Therefore, I specially concur.

In the Matter of the Compensation of
DONALD W. POOSCHKE, JR., Claimant
WCB Case No. 90-07461
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Garaventa's order that affirmed an Order on Reconsideration awarding claimant 19 percent (28.5 degrees) scheduled permanent disability for loss of use or function of the right knee. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the Referee's order as supplemented below.

This case involves a consolidated hearing on two closures: a May 7, 1990 Notice of Closure awarding 15 percent scheduled permanent disability, and an October 7, 1991 Determination Order which increased claimant's scheduled award to 19 percent. Claimant's hearing request on the initial Notice of Closure was deferred when his claim was reopened for surgery. That hearing request was later reactivated and consolidated with claimant's subsequent hearing request from the Determination Order.

The Referee concluded that claimant's disability should be rated under the standards in effect at the time of the Determination Order, when claimant was last medically stationary. (WCD Admin. Orders 2-1991 and 17-1992). On review, claimant argues that his disability should be rated under the standards in effect at the time of the earlier Notice of Closure, when he initially requested a hearing. (WCD Admin. Order 7-1988.)

We agree with the Referee's conclusion that Board case law and Department rules require application of the standards in effect at the time of the Determination Order, when claimant was last medically stationary. OAR 436-35-003(2); Susannah Rateau, 43 Van Natta 135 (1991); Wade A. Webster, 42 Van Natta 1707 (1990).

We write only to address a constitutional challenge claimant raises for the first time on review. Claimant contends that not rating his disability under the earlier standards in effect at the time of the initial Notice of Closure is fundamentally unfair and a violation of his due process rights under the U. S. Constitution. See State ex rel Juvenile Department v. Geist, 310 Or 176 (1990); Tupper v. Fairview Hospital, 276 Or 657 (1976).

Claimant's argument assumes that he would receive a greater award under the earlier standards. Specifically, claimant contends that the +10 surgery value and +5 chronic condition value he would receive under the earlier standards would not adequately compensate him for his chondromalacia condition and, thus, he would be entitled to an award of 22 percent permanent disability outside the standards under former ORS 656.283(7). Pursuant to that provision, a claimant could establish that the record, as a whole, constitutes clear and convincing evidence that the disability suffered was more than the entitlement indicated by the "standards".

For the sake of claimant's argument, we assume that he would be able to establish that the aforementioned surgery and chronic condition values would not adequately compensate him for his disability. Nevertheless, based on the record presently before us, claimant has not established by clear and convincing evidence that his current award of 19 percent scheduled permanent disability does not adequately compensate him for his total right knee disability, including any additional disability associated with his chondromalacia.

Thus, claimant would not be entitled to a greater award under the earlier standards. It therefore follows that the Referee's decision not to apply those standards is neither fundamentally unfair or a violation of claimant's due process rights.

Accordingly, as supplemented above, we adopt the Referee's order affirming the Department's award of 19 percent scheduled permanent disability for claimant's right knee condition.

ORDER

The Referee's order dated June 7, 1993 is affirmed.

In the Matter of the Compensation of
JACK W. SIZEMORE, Claimant
WCB Case No. 93-08000
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Neidig.

Claimant requests review of that portion of Referee Lipton's order that upheld the insurer's "de facto" denial of his aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable low back injury on October 31, 1988. His claim was closed by Notice of Closure on July 5, 1989; no award of permanent disability was made at that time. Claimant filed an aggravation claim in 1989. The claim was closed by Stipulation and Order on January 5, 1990, and claimant was awarded 5 percent unscheduled permanent disability.

On March 6, 1992, claimant's treating physician, Dr. Constien, M.D., noted that claimant was experiencing markedly increased low back pain pursuant to lifting activities at work during the previous three or four weeks. (Ex. 11). Dr. Constien diagnosed an "aggravation of previous lumbosacral injury," and prescribed chiropractic care with Dr. Milanovich, D.C. (Ex. 11).

Claimant returned to Dr. Constien on June 18, 1992, complaining of the most severe low back pain he had experienced in the last 18 months; his complaints included aching in his right knee and proximal lateral calf. (Ex. 14). Dr. Constien noted that claimant was quite uncomfortable and "has just been sitting in his truck or laying on the hood at work." (Ex. 14). Claimant's treating physician diagnosed "aggravation of [claimant's] pain, now with sacroiliac inflammation," and authorized claimant to treat with Dr. Milanovich on a more frequent basis. (Ex. 14).

On July 7, 1993, claimant requested a hearing, alleging a "de facto" denial of his aggravation claim of March 6, 1992, and seeking penalties and attorney fees for unreasonable claims processing. The Referee found that claimant had proven a symptomatic worsening of his compensable low back condition. However, the Referee concluded that claimant had failed to demonstrate diminished earning capacity as a result of his worsened condition. Accordingly, the Referee found that claimant had not proven an aggravation. We disagree.

In order to establish a compensable aggravation claim for an unscheduled condition, claimant must prove by a preponderance of the evidence that: (1) since the last award of compensation, he suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991).

Inasmuch as we agree with, and adopt, the Referee's conclusion that claimant established a symptomatic worsening, we need not address that element of his aggravation claim. Therefore, we limit our discussion to the remaining elements of an aggravation that claimant is required to prove: (1) diminished earning capacity, and (2) worsening beyond any waxing and waning contemplated by the last arrangement of compensation.

Claimant asserts that the Referee upheld the insurer's denial because claimant was unable to provide medical verification of his inability to work. (i.e., authorization for temporary disability). The Referee reasoned that claimant continued to work at his regular position throughout the period that his treating physician, Dr. Constien, was attempting to obtain authorization so that Dr. Milanovich could provide palliative care. (Ex. 15).

Claimant does not dispute that he continued to work in his regular supervisory position during the period of time that his symptoms worsened and required palliative treatment. Likewise, claimant does not challenge the Referee's finding that Dr. Constien did not restrict claimant's work activities during this alleged aggravation.

Claimant relies upon Stanley Stevens, 45 Van Natta 1073 (1993), and Michael C. Dewbre, 45 Van Natta 1097 (1993), for the proposition that he is not required to prove that he is entitled to temporary disability benefits in order to establish a loss of earning capacity. Cf. Michael K. Janes, 44 Van Natta 1817 (1992). We agree.

In Stevens, the claimant's employer testified that the claimant was not physically able to perform some of the same duties that he could perform after his last arrangement of compensation. The claimant's treating physician also noted a marked deterioration in the claimant's physical abilities. Id. However, the claimant did not receive any temporary disability benefits. The Board concluded that the aforementioned comparisons of claimant's physical capacity (i.e., by claimant's treating physician and his employer at the time of the worsening) before and after the worsening were sufficient to carry claimant's burden of proof on the issue of diminished earning capacity.

In Dewbre, the claimant was never released from work due to his worsened condition. However, as in Stanley, the Board reasoned that the claimant was less able to work due to significantly reduced ranges of motion, impingement sign, inflammation and increased work restrictions. Furthermore, two doctors recommended that claimant change jobs to alleviate the symptoms. Id. at 1098. Accordingly, the Board found that the claimant had established an aggravation claim.

Relying on Stevens and Dewbre, claimant contends that he has established a diminished earning capacity based on his testimony regarding his temporary inability to perform regular duties (e.g., picking up vegetation and feeding it through a chipping machine). (Tr. 16). Dr. Constien's chart notes support claimant's testimony. (Ex. 14). Furthermore, Dr. Constien's chart notes of June 12, 1992, reveal that claimant was gradually becoming more active at work (e.g., climbing trees and using a "tree cutter") following his June worsening, but prior to his July worsening that left him completely unable to do anything more than supervise. This medical and lay evidence is not rebutted.

Claimant argues that the Referee impliedly found no loss of earning capacity because claimant had never been released from work due to his worsened condition. Claimant reasons that his testimony, as corroborated by his treating physician, demonstrates that he was temporarily less able to work as a result of his symptomatic worsening; and, therefore, his earning capacity was diminished. We agree. See Edward D. Lucas, supra.

Based on the foregoing reasoning, we find that claimant was less able to work following both the June and July exacerbations of 1992. See ORS 656.273(1); Smith v. SAIF, 302 Or 396, 399 (1986); Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993). Therefore, this record establishes that claimant suffered diminished earning capacity as a result of his symptomatic worsening in June and July of 1992.

Lastly, we address whether claimant's worsening exceeded any waxing or waning that might have been contemplated at the last award of compensation.

When there is medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, supra. Here, there is no evidence of any predictions of future flare-ups prior to the January 5, 1990, Stipulation and Order that awarded claimant 5 percent unscheduled permanent disability. There is no indication that the Stipulation and Order award was based on a chronic condition. (Ex. 30). See Theodore W. Kinder, 46 Van Natta 391, 393 (1994).

The medical evidence in existence at the time of the last award of compensation does not support a finding that the Stipulation and Order "contemplated" future waxing and waning of symptoms of the low back condition. See Debra K. Donovan, 45 Van Natta 1175, 1176-77 (1993); Linda J. Hughes-Smith, 45 Van Natta 827, 828 (1993). Consequently, we conclude that the last award of compensation did not contemplate future waxing and waning of the compensable condition. Accordingly, we find that claimant has satisfied his burden of proving a compensable aggravation claim.

Claimant is entitled to an assessed attorney fee for services at hearing and on review regarding the claim for aggravation. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $2,600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief and the hearing record), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated October 15, 1993 is reversed. The insurer's denial is set aside, and the aggravation claim is remanded to the insurer for processing according to law. For services at hearing, and on Board review, claimant's attorney is awarded an assessed fee of $2,600, payable by the insurer.

Board Chair Neidig dissenting.

The majority found that claimant satisfied the diminished earning capacity requirement for an unscheduled aggravation claim. I disagree, and would affirm the Referee's order.

The only proof of diminished earning capacity that claimant offers is his own testimony. This is insufficient to satisfy claimant's burden when that same testimony indicates that claimant continued to perform his usual and customary work without medical restriction (i.e., performing his supervisory duties full-time in return for his regular wages). Therefore, under the circumstances, claimant's symptomatic increase did not render him less able to work. See Douglas A. Eichensehr, 44 Van Natta 1755 (1992).

As a matter of public policy, the majority's decision serves to frustrate the well intentioned efforts of employers who continue to provide full-time employment to their injured workers. If an injured worker is capable and willing to continue working despite transient discomfort, it is counterintuitive that we should restrict the employer's flexibility to accommodate that worker's desire to remain productive by modifying the relevant physical aspects of that worker's job duties.

However, the majority's application of the diminished earning capacity principle would discourage this sort of cooperation between employers and workers, inasmuch as the employer has no incentive to make potentially costly work accommodations when the injured worker may very well be found to have an aggravation claim substantiated by those modified work activities. Rather, it is likely that the employer will demand that the injured worker either obtain a doctor's release from work, or continue to perform the exact same duties as normal, without regard to discomfort.

Accordingly, I dissent.

In the Matter of the Compensation of
PATRICIA V. STANDARD-FRANKLIN, Claimant
WCB Case Nos. 92-16329, 92-16015 & 92-14924
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests, and Connecticut Indemnity (EBI) cross-requests, review of Referee Myzak's order that: (1) set aside SAIF's November 10, 1992 denial of claimant's low back strain new injury claim; (2) upheld SAIF's denial of claimant's low back degenerative disc disease; (3) set aside EBI's denial of claimant's aggravation claim for low back degenerative disc disease; (4) upheld EBI's denial for claimant's low back strain; and (5) affirmed an Order on Reconsideration that awarded claimant 5 percent (6.75 degrees) scheduled permanent disability under her EBI claim for loss of use of function of the right foot. On review, the issues are compensability, responsibility and extent of right foot permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant objects to SAIF's reply/cross-respondent's brief and contends that, because SAIF failed to submit an appellant's brief, claimant has had no opportunity to respond to SAIF's arguments about her credibility. Claimant requests that we strike SAIF's brief.

SAIF's "reply/cross-respondent's brief" was not "in lieu" of an appellant's brief. Rather, the brief was in reply to EBI's respondent/cross-appellant's brief. Had SAIF wished to merely rely on the Referee's reasoning, it could have done so in a letter, specifically waiving its opportunity to submit a brief. However, because EBI chose to file a respondent/cross-appellant's brief, SAIF was entitled to file a reply. See George T. Cooper, 44 Van Natta 493 (1992); Virgil Brogan, 40 Van Natta 67 (1987).

Inasmuch as SAIF's reply brief was not a resubmitted appellant's brief and was timely filed, it will be considered on Board review. Accordingly, the motion to strike SAIF's brief is denied.

Alternatively, claimant submits a "cross-reply brief" to respond to SAIF's argument about her credibility. The rules do not expressly provide for submission of a reply brief by a cross-respondent. See OAR 438-11-020(2) (WCB Admin. Rules 1-1993) (no other briefs will be considered unless otherwise authorized by the Board). However, in light of SAIF's failure to file an appellant's brief and its subsequent arguments about claimant's credibility, we find it appropriate to consider claimant's "cross-reply brief."

Compensability

We consider first whether ORS 656.308(1) applies to this claim. To answer this question we need to determine if claimant's current condition for which she seeks compensation involves a condition that has previously been processed as part of a compensable claim. See Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993).

The Referee found that claimant's degenerative disc condition was an accepted component of her EBI claim and concluded that the "law of the case" was that EBI's accepted conditions in July 1992 were a low back strain superimposed on claimant's underlying degenerative disc disease. The Referee reasoned in part that SAIF had been previously found responsible for claimant's degenerative disc condition under a prior claim as a result of her 1986 injury and her May 1987 aggravation claim. EBI argues that claimant's degenerative disc disease was a preexisting condition and was not part of EBI's previous claim. We disagree.

In May 1986, claimant sustained a compensable injury while working for SAIF's insured, Eugene Hospital (not a party to this proceeding). On May 17, 1987, claimant strained her back while working for Oregon Medical Laboratories, which was insured by EBI. Although SAIF and EBI initially denied the claim, SAIF later accepted the May 1987 aggravation claim by stipulation. (Ex. 48).

A March 29, 1988 Determination Order awarded claimant 20 percent unscheduled permanent partial disability for her low back. (Ex. 46). The Determination Order was affirmed on July 12, 1988 by Referee Brazeau. (Ex. 49). Referee Brazeau found that claimant had compensably injured her low back in April 1986 and was diagnosed as having suffered a low back strain. He found further that "X-rays revealed significant preexisting degenerative disk disease, aggravated and worsened by the compensable injury." (Id.) That finding is supported by reports from the attending physician, Dr. Davis, an orthopedic surgeon, and from Dr. Golden. In October 1986 Dr. Davis reported that claimant had "developed a symptomatic degenerative lumbar disk disease which became aggravated because of her work on the job." (Ex. 26). Dr. Golden concurred with his opinion. (Ex. 28).

In the present case, the Referee reasoned alternatively that, even if the degenerative disc disease was not a compensable condition for which SAIF was responsible, the degenerative disc disease was an acceptable component of the condition for which the Arbitrator had previously ordered EBI to be responsible.[1] A January 30, 1990 Arbitrator's Decision found that claimant's degenerative low back condition was materially worsened by her January 1989 injury while EBI was on the risk. The Arbitrator found:

> "A further back strain occurred on May 2, 1986 and was accepted by SAIF as an aggravation of the condition from the Eugene Clinic injury in 1985. Radiographic examination of claimant's back during this period had already disclosed 'precocious' degenerative disc disease in the low back." (Ex. 76).

The Arbitrator relied on the opinions of Drs. Davis and Woolpert to assign responsibility to EBI. Dr. Davis agreed that the January 23, 1989 injury "further worsened the degenerative lumbar disc disease condition, rather than simply causing it to become symptomatic." (Ex. 66). Dr. Woolpert, orthopedic surgeon, concluded that claimant had a "worsening of the condition rather than just a change in symptoms due to the 1/89 injury." (Ex. 72). The Arbitrator concluded that claimant had "sustained an injury to her low back on January 23, 1989, that materially worsened her degenerative low back condition" and assigned responsibility to EBI. (Ex. 76). The Arbitrator's Decision was subsequently affirmed by the Board (Ex. 103) and was not appealed. (Tr. 10-11).

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[1] EBI focuses on the Referee's additional conclusion that claimant's condition was not temporary in nature and would not improve. EBI's argument misses the mark. Whether or not claimant's degenerative disc condition is temporary or permanent is not relevant to the issue currently before us, i.e., whether claimant's current condition for which she seeks compensation involves a condition that has been previously processed as part of a compensable claim. We conclude that EBI is precluded from arguing that it is not responsible for claimant's degenerative disc disease.

Under the res judicata doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined by a valid final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. Drews v. EBI Companies, 310 Or 134, 139-40 (1990); North Clackamas School Dist. v. White, 305 Or 48, 50, modified 305 Or 468 (1988).

We conclude that the January 30, 1990 Arbitrator's Decision, which was affirmed by the Board and not appealed, established as a matter of law that claimant's degenerative disc disease is compensable under claimant's EBI claim. Therefore, EBI is precluded from arguing now that it was a preexisting condition and not an accepted component of her claim. See Weyerhaeuser Co. v. Pitzer, 123 Or App 1 (1993). We also agree with the Referee that the evidence establishes that claimant's current condition is compensable. Inasmuch as claimant's degenerative disc disease is the "same condition" for which responsibility is presently disputed, ORS 656.308(1) applies to this claim.

Responsibility

The Referee found that claimant had sustained a new strain injury on July 15, 1992, which resulted in her current disability and need for treatment. Therefore, the Referee concluded that SAIF (as an insurer for a subsequent employer) was responsible for claimant's strain.

First, we address SAIF's argument that claimant was not truthful when she described a new injury that allegedly occurred on July 15, 1992. SAIF argues that claimant is "familiar with the concepts of aggravation and new injury," and despite this, she did not report her new injury for three months. We agree with the Referee that to accept SAIF's contention we would have to hold claimant to an unrealistic standard of medical and legal expertise. We affirm the Referee's finding that claimant was a credible witness.

Nevertheless, we do not agree with the Referee's conclusion that claimant sustained a "new injury" on July 15, 1992. Subsequent to the Referee's order, the Supreme Court issued its decision in SAIF v. Drews, 318 Or 1 (1993). The Court ruled that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). Therefore, in order to shift responsibility for a "new injury" from EBI to SAIF, EBI must establish that the July 15, 1992 injury at SAIF's insured is the major contributing cause of claimant's current disability or need for treatment.

Considering claimant's history of prior injuries and complaints, we find that the causation issue is a complex medical question requiring expert medical opinion to resolve. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). When there is a dispute between medical experts, we give more weight to medical opinion that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We conclude that the medical evidence establishes that claimant's work activities on July 15, 1992 were not the "major contributing cause" of her current disability or need for treatment.

Dr. Stanford, an orthopedic surgeon, and Dr. Peterson, a neurologist, examined claimant in December 1992. Dr. Stanford had previously examined claimant for an arbiter exam on June 22, 1992. (Ex. 120). Drs. Stanford and Peterson reported that the major cause of claimant's current condition was her ongoing and longstanding degenerative arthritis in her lumbar spine. (Ex. 148). They concluded that claimant's injuries had not done anything to contribute to the degenerative condition in her back. They also reported:

> "Whatever happened on July 13, 1992 was a very minor physical incident as described by [claimant]. It doesn't make a lot of medical sense. * * * If, indeed, it is causing her real symptoms, it would by definition be related to the degenerative problems in her low back, and certainly not due to an injury on July 15, 1992." (Ex. 148).

Dr. Arbeene, an orthopedist, examined claimant in January 1993. He reported that "the major contributing cause of [claimant's] current condition and need for treatment is the multiple level degenerative lumbar disc disease that she has, and that it is unrelated to her 1989 claim, or for that matter, to any of her other claims." (Ex. 152).

Unless there are persuasive reasons not to do so, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). In this case we find persuasive reasons not to defer to Dr. Kitchel since he provided inconsistent opinions regarding claimant's condition.

In May 1991 Dr. Kitchel had concurred with Dr. Hazel's conclusion that claimant's progressive degenerative disc disease would "continue to be episodically symptomatic with or without provocation or, more commonly with physical provocation that would be considered ordinarily to be trivial." (Exs. 109 & 110). After claimant's July 15, 1992 incident, Dr. Kitchel reported on August 25, 1992 that the major current cause of claimant's time loss was her May 1986 injury. (Ex. 129). At that time, he stated: "I have been through her history a number of times and talked specifically about any new or intervening injury. There does not appear to be any new injury." (Id.; emphasis added).

Dr. Kitchel later changed his opinion and reported that claimant's current condition was primarily related to her July 15, 1992 injury. (Ex. 146). In a deposition, Dr. Kitchel explained that he had changed his opinion because of a better understanding of claimant's history. (Ex. 153-12).

Dr. Kitchel's justification for his change of opinion on the basis of claimant's history does not sufficiently explain his change of opinion. See Kelso v. City of Salem, 87 Or App 630 (1987). Moreover, Dr. Kitchel does not rebut Drs. Stanford and Peterson's conclusion that the July 15, 1992 was a "very minor physical incident" and did not "make a lot of medical sense." Furthermore, in light of Dr. Kitchel's previous concurrence with Dr. Hazel that claimant's degenerative disc disease would continue to be symptomatic "with or without provocation," we are not persuaded that the July 15, 1992 incident was the major contributing cause of her current condition. Therefore, we attach little probative value to Dr. Kitchel's opinion.

We conclude that EBI has not sustained its burden of proving that claimant sustained a new injury during his employment with SAIF's insured. Consequently, responsibility for claimant's current low back degenerative condition remains with EBI. Likewise, EBI is responsible for the Referee's $1,500 attorney fee award. Accordingly, we reverse those portions of the Referee's order.

Extent

The July 2, 1992 Order on Reconsideration awarded claimant 5 percent scheduled permanent disability for loss of sensation in her right foot. (Ex. 123). EBI contends that claimant is not entitled to the award because she is relying on the "same findings as before" and she should not be able to collaterally attack a prior Determination Order. According to EBI, the medical arbiter found the same decrease in sensation that Dr. Becker had previously noted. We disagree.

On May 4, 1990, Dr. Becker reported "[s]ensibility to light touch and pinprick reveals slight decrease in pin perception in the right medial calf and ankle." (Ex. 84). In contrast, Dr. Stanford's arbiter examination on June 22, 1992 noted decrease sensation in claimant's right foot. (Ex. 120). We agree with the Referee that claimant is entitled to 5 percent scheduled permanent disability for loss of sensation in her right foot.

Inasmuch as EBI requested Board review and we have found that claimant's compensation under the EBI claim should not be disallowed or reduced, claimant is entitled to an attorney fee award for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 435-15-010(4), we find that a reasonable fee for claimant's counsel's services on review is $1,500, payable by EBI. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated October 25, 1993, as amended on October 29, 1993, is reversed in part and affirmed in part. SAIF's denial is reinstated and upheld. EBI's denial is set aside in its entirety and the claim is remanded to EBI for processing according to law. The attorney fee award of $1,500 that the Referee ordered to be paid by SAIF shall be paid by EBI. In all other particulars, the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded $1,500, to be paid by EBI.

In the Matter of the Compensation of
WILLIAM T. WYLAND, Claimant
WCB Case No. 93-02196
ORDER ON REVIEW
Nancy Chapman, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Garaventa's order that directed the insurer to calculate claimant's rate of temporary disability benefits based on an average weekly wage of $250. On review, the issue is rate of temporary disability.

We adopt and affirm the Referee's order with the following supplementation.

We agree with the Referee that OAR 436-60-025(5)(a) applies to this case. That rule provides that when workers paid by piece work have been employed less than four weeks, "insurers shall use the intent at the time of hire as confirmed by the employer and the worker." The Referee found that claimant and the employer agreed at the time of hire that claimant would be paid under the same arrangement as when he had previously worked for IRT under different ownership, which was $250 per week.

On review, claimant argues for the first time that the Referee erred because temporary total disability should have been calculated from claimant's gross weekly wage rather than his net weekly wage. We are not inclined to consider claimant's argument because claimant failed to adequately raise the issue before the Referee.

Nevertheless, we conclude that claimant did not present sufficient evidence as to the amount of his previous gross weekly wage. Claimant testified that when he went to work for the employer, he understood that the agreement was "on a percentage basis, the same as before." (Tr. 10). Claimant testified that when he previously worked for IRT under different ownership, he brought home "at least $500 every two weeks" after taxes. (Tr. 8-9). Claimant's previous employer, Gregory L. Brown, stated that claimant's pay checks averaged approximately $500 every two weeks. (Ex. 15A).

Although claimant offers several options for us to calculate his previous average weekly wage, the record does not clearly establish the amount of claimant's gross weekly wage when he previously worked for IRT under different ownership. Under the circumstances, we conclude that claimant has not established that his rate of temporary disability benefits should be based on an average weekly wage greater than $250. See ORS 656.266.

ORDER

The Referee's order dated November 10, 1993 is affirmed.

In the Matter of the Compensation of
GREGORY J. CAMERON, Claimant
WCB Case No. 92-15349
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of those portions of Referee Crumme's order that: (1) affirmed an Order on Reconsideration awarding 31 percent (7.44 degrees) scheduled permanent disability for loss of use or function of the left index finger, whereas a Determination Order awarded 44 percent (10.56 degrees); (2) authorized the SAIF Corporation to offset overpaid temporary disability compensation against temporary disability benefits due under this claim; and (3) declined to award an approved fee payable out of that portion of SAIF's offset request that was not ultimately authorized by the Referee. On review, the issues are extent of scheduled permanent partial disability, offset, and attorney fees. We modify the authorized offset and affirm on the remaining issues.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate fact with the exception of his ultimate finding that claimant's only ratable loss is his 48 degrees of flexion in the distal interphalangeal (DIP) joint. We make the following additional finding.

Claimant has 28 degrees retained motion in the DIP joint and 90 degrees retained motion in the proximal interphalangeal (PIP) joint.

Claimant is able to distinguish two pin pricks four millimeters apart applied at the same time.

Claimant has no lost grip strength attributable to nerve injury or muscle loss or disruption.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Partial Disability

Claimant contends that the Referee erred in affirming an Order on Reconsideration awarding 31 percent scheduled permanent disability for lost range of motion in claimant's left index finger. Claimant argues that he has also sustained a loss of sensation and grip strength, as well as a greater loss of motion. We disagree.

Range of Motion. At hearing, claimant relied solely on lost range of motion as a basis for an increased disability award. The Referee concluded that claimant's lost motion was limited to 48 degrees retained flexion in the distal interphalangeal (DIP) joint, for a total award of 14 percent scheduled permanent disability. Nevertheless, the Referee affirmed the Order on Reconsideration award of 31 percent scheduled permanent disability as SAIF had not requested a decrease in the award.

In rating claimant's disability, the Referee relied on the findings of Dr. Fuller, the medical arbiter. On review, claimant contends that Dr. Fuller's findings establish a loss of both extension and flexion, whereas the Order on Reconsideration only awarded a value for lost flexion.

We agree that Dr. Fuller's findings establish a loss of both flexion and extension. We also conclude that the Referee erred in finding that claimant's ratable disability was limited to 14 percent for lost flexion in the DIP joint. However, we do not agree with claimant's contention that the Order on Reconsideration failed to rate claimant's loss of extension.

Dr. Fuller reported that claimant's DIP joint lacked full extension by 20 degrees and had flexion to 48 degrees, and that the proximal interphalangeal (PIP) joint lacked full extension by 10 degrees but had full flexion to 100 degrees. Based on this report, we find that claimant retained 28 degrees of motion in the DIP joint and 90 degrees of motion in the PIP joint. Accordingly, the Order on Reconsideration correctly awarded claimant 27.2 percent for 28 degrees retained motion in the DIP joint and 6 percent for 90 degrees retained motion in the PIP joint, for a combined award of 31 percent. OAR 436-35-060(1) and (3).

Sensation. No value is given under the standards if enough sensitivity remains to distinguish two pin pricks six millimeters apart applied at the same time. OAR 436-35-110(1)(a). Here, Dr. Fuller noted contradictory sensory findings, and he concluded that claimant had at least 4 millimeters of 2-point discrimination over the tip of the left index finger. The treating physician, Dr. Layman, reported normal sensibility at claimant's closing examination. On this record, claimant has not established a ratable loss of sensation under the standards.

Grip Strength. Lost grip strength is ratable under the standards only if it is due to peripheral nerve injury, muscle loss or disruption of the musculo tendonous unit. OAR 436-35-110(8). Here, Dr. Fuller did not report lost grip strength. Dr. Layman did note less grip strength on the left than the right in his closing examination. However, he does not attribute this loss to a nerve injury or muscle loss or disruption. Moreover, any lost strength due to decreased motion is addressed in claimant's separate award for lost range of motion. OAR 436-35-110(8)(c). Claimant is not entitled to a separate award for lost grip strength.

Accordingly, subject to our disagreement with the Referee's range of motion calculation, we adopt the Referee's ultimate decision to affirm the Order on Reconsideration award of 31 percent scheduled permanent disability.

Offset

Claimant contends that the Referee erred in authorizing SAIF to offset an overpayment of temporary disability against "temporary disability that was payable but not paid, as distinguished from temporary disability payable in the future." We agree. An insurer may not offset an overpayment against temporary disability compensation, whether those benefits are currently due or awarded in the future. Jon C. Millet, 42 Van Natta 1971 (1990); Iola P. Carr, 42 Van Natta 1537 (1990); William J. Dale, 39 Van Natta 632 (1987); Harold D. Bates, 38 Van Natta 992 (1986). An offset may only be taken against future permanent disability awards. Id. Accordingly, we modify the Referee's order to limit the authorized offset to future awards of permanent disability in this claim.

Approved Fee for Unauthorized Offset

Claimant contends that he is entitled to an approved fee payable out of the difference between the amount of SAIF's initial offset request and the lower offset ultimately authorized by the Referee. We conclude that claimant is not entitled to an approved fee under the particular circumstances of this case.

As part of its claim processing obligations, SAIF paid temporary disability compensation based on a 45-hour work week through August 18, 1991. After that date, SAIF paid temporary disability based on a 32-hour work week. Claimant requested a hearing, contending that SAIF should have continued to base his temporary disability on a 45-hour work week.

SAIF cross-requested a hearing, seeking an offset for its alleged overpayment of temporary disability at the higher 45-hour week rate through August 18, 1991. SAIF also requested a separate offset for all temporary disability paid after August 18, 1991, but it later withdrew this offset request at hearing.

The Referee concluded that claimant was entitled to temporary disability based on a 45-hour work week. Accordingly, the Referee ordered SAIF to pay the additional post-August 18, 1991 temporary disability due at this higher rate, and he awarded an approved fee payable out of the additional compensation. Consistent with this ruling, the Referee denied SAIF's requested offset for an alleged overpayment of temporary disability at the higher rate through August 18, 1991.

On review, claimant requests an additional approved fee payable out of the temporary disability previously paid by SAIF after August 18, 1991, and the temporary disability paid prior to that date to the extent it was based on a 45 rather than a 32-hour week. Claimant contends that he is entitled to this additional approved fee because SAIF's offset requests for these payments were either withdrawn or denied by the Referee.

In analyzing claimant's fee request, we are guided by the Board's analysis in Anthony E. Cochrane, 42 Van Natta 1619 (1990). The claimant in Cochrane requested a hearing to establish a substantive right to temporary disability previously paid out on a procedural basis. After concluding that the claimant was substantively entitled to the requested compensation, the referee awarded an approved fee payable out of that compensation.

The Cochrane Board concluded that the approved fee was correctly awarded under OAR 438-15-045. That rule authorizes an approved fee when a claimant requests a hearing on extent of temporary disability, and the referee awards additional temporary disability compensation. The Board reasoned that the referee had awarded additional temporary disability compensation within the meaning of OAR 438-15-045 because the award of substantive temporary disability had effectively defeated any offset claim for the previously paid compensation.

The present case is distinguishable from Cochrane on its facts. Here, the Referee did not award substantive temporary disability for the periods corresponding to the unauthorized offsets. Moreover, these offsets were placed in issue by SAIF in its cross-request for hearing. The offsets were not defeated as a result of claimant's hearing request, which concerned a separate entitlement of temporary disability compensation. Accordingly, the unauthorized offsets were not an award of additional temporary disability compensation within the meaning of OAR 438-15-045. Claimant is not entitled to the requested approved fee for services at hearing regarding the offset issue.

Finally, we note that claimant is not entitled to a fee for services on Board review regarding our limitation of the Referee's authorized offset to future awards of permanent disability compensation. Inasmuch as our modification of the offset authorization has not resulted in increased compensation, claimant is not entitled to an attorney fee award.

ORDER

The Referee's order dated July 12, 1993 is modified in part and affirmed in part. The offset authorized by the Referee is limited to future permanent disability benefits awarded in this claim. The remainder of the Referee's order is affirmed.

August 1, 1994 Cite as 46 Van Natta 1581 (1994)

In the Matter of the Compensation of
DONALD R. VANDYKE, Claimant
WCB Case Nos. 93-06606, 93-05238, 93-02832 & 93-06605
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Breathouwer, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Holtan's order that declined to award claimant's counsel an attorney fee pursuant to ORS 656.386(1). Alternatively, claimant seeks a penalty for Aetna's allegedly unreasonable resistance to the payment of compensation for failure to request a paying agent pursuant to ORS 656.307. On review, the issue is attorney fees and, alternatively, penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, since Aetna did not deny compensability, but rather only disclaimed responsibility, claimant's counsel was not entitled to a fee pursuant to ORS 656.386(1). See Gamble v. Nelson International, 124 Or App 90, 94 (1993) (when a carrier withdraws its responsibility disclaimer before hearing, the claimant is not entitled to an attorney fee under ORS 656.386(1)).

ORS 656.386(1) provides, in part, "If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Subsequent to the Referee's order, we have held that a claimant's counsel is entitled to a carrier-paid attorney fee under that statute when a carrier rescinds the compensability portion of its denial prior to a hearing regarding responsibility for the claim. Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994).

Because Aetna agreed "that there is a compensable bilateral carpal tunnel syndrome [CTS] workers' compensation claim for which they are responsible" and agreed to accept responsibility immediately before the hearing regarding the responsibility for that condition, under Hamrick, claimant's counsel is entitled to a reasonable attorney fee pursuant to ORS 656.386(1).

On review, Aetna argues that it never denied compensability and that its denials were limited to responsibility. Aetna points to its comments in both notices that "another carrier is responsible." Therefore, Aetna contends that ORS 656.386(1) does not apply. We disagree.

Aetna issued two denials; one dated February 22, 1992, and one dated April 16, 1992. Its April 1992 denial is entitled "SUPPLEMENTAL DENIAL." This denial states, "Please be advised we are denying responsibility and are also denying compensation, as we believe another carrier is responsible[.]" (emphasis added). The denial concludes by reciting: "THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS. * * *" We find that Aetna's April 1992 denial was a denial of compensation as well as a denial of responsibility.

The Court of Appeals has held that "[carriers] are bound by the express language of their denials[.]" Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993). Therefore, Aetna's current representation of the purported meaning of its April 1992 written denial is irrelevant. See id. at 351-52. Here, the title of Aetna's April 1992 denial reveals that, in addition to disclaiming responsibility, Aetna intended to deny claimant's claim. We do not find that Aetna's comment that "another carrier is responsible," renders its compensability denial a disclaimer of responsibility only. Instead, read as a whole, the denials can mean only one thing: Aetna intended to deny the compensability of, as well as responsibility for, claimant's current condition. Accordingly, we conclude that Aetna's representations regarding its intent to deny only responsibility for claimant's CTS are irrelevant. Tattoo v. Barrett Business Service, supra, 118 Or App at 351-52.

OAR 438-05-053 supports this conclusion. Subsection (4) of that rule provides that "[a] notice of intent to disclaim responsibility that is also a denial of compensation shall include the following notice, in prominent or bold-face type, using the following paragraph divisions: 'THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS. * * *'" OAR 438-05-053(4) (emphasis added). In contrast, subsection (3) of the rule provides that "[a] notice of intent to disclaim responsibility that is not a denial of the claim shall include the following notice, in prominent or bold-face type, using the following paragraph divisions: 'THIS IS A NOTICE THAT WE BELIEVE ANOTHER EMPLOYER OR INSURER MAY BE RESPONSIBLE FOR YOUR CONDITION AND BENEFITS. * * *'" OAR 438-05-053(3) (emphasis added).

Aetna's April 1992 denial contains bold-face paragraphs that begin, "THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS," and includes the language expressly required by OAR 438-05-053(4) in the case of a disclaimer of responsibility that is coupled with a denial of compensability.[1] For this reason, we conclude that Aetna denied the compensability of, as well as the responsibility for, claimant's CTS. See Johnny M. Davis, 45 Van Natta 2282 (1993).

To reiterate, under Hamrick, claimant's counsel is entitled to a reasonable attorney fee pursuant to ORS 656.386(1) for his counsel's efforts in obtaining the withdrawal of the compensability portion of Aetna's April 1992 denial prior to hearing. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's pre-hearing services concerning the rescission of the compensability denial is $2,000, to be paid by Aetna. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

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[1] Aetna's February 22, 1992 notice tracked the language set forth in OAR 438-05-053(3), which governs notices of intent to disclaim responsibility only. We agree with the Referee that this denial was a denial of responsibility only.

We further note that claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue in this case. Martin E. Mendez-Equibel, 45 Van Natta 959 (1993); see Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Because we have ruled in claimant's favor on his argument under ORS 656.386(1), we do not reach claimant's alternative argument regarding a penalty for Aetna's allegedly unreasonable resistance to the payment for compensation for failure to request a paying agent pursuant to ORS 656.307.[2]

ORDER

The Referee's order dated October 28, 1993 is affirmed in part and reversed in part. For pre-hearing services regarding the compensability issue, claimant's counsel is awarded $2,000, to be paid by Aetna. The remainder of the Referee's order is affirmed.

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[2] Moreover, the Referee awarded a penalty of 25 percent of the compensation due from December 23, 1992 through April 16, 1992, for Aetna's unreasonable claims processing pursuant to ORS 656.262(10). ORS 656.382(1) authorizes the assessment of an attorney fee if an insurer unreasonably resists the payment of compensation, provided that there are no amounts of compensation then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10). Corona v. Pacific Resource Recycling, 125 Or App 47 (1993); Oliver v. Norstar, Inc., 116 Or App 333 (1993); Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992).

In the Matter of the Compensation of
CHARLES E. TRENTO, Claimant
Own Motion No. 66-0290M
OWN MOTION ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
SAIF Legal Department, Defense Attorney

Claimant seeks Board authorization of an approved fee for his attorney's services culminating in our July 21, 1994, Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amound of 25 percent of the increased temporary disability compensation is awarded under this order, not to exceed $1,050, payable by the SAIF Corporation directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

Accordingly, our July 21, 1994, order is abated and withdrawn. As amended herein, we adhere to and republish our July 21, 1994, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOLPH M. WIEDENMANN, Claimant
WCB Case No. 92-15047
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of that portion of Referee McCullough's order that set aside the insurer's partial denial, as orally amended at hearing, of claimant's September 1992 cervical surgery and medical treatment related to claimant's osteoarthritic spur. On review, the issues are the propriety of the denial and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception. On page 3 of the Referee's order, the Referee found that the insurer amended its November 10, 1992 partial denial to provide that it was not denying treatment subsequent to September 9, 1992 that was medically related to claimant's cervical strain. Instead, we find that the insurer attempted to amend its denial at hearing, and claimant objected to that attempted amendment.

CONCLUSIONS OF LAW AND OPINION

At hearing, the Referee allowed the insurer to orally amend its partial denial of claimant's cervical surgery. As amended, the Referee upheld the insurer's denial of claimant's cervical surgery to remove an osteoarthritic spur and medical treatment related to the spur, as opposed to claimant's compensable cervical strain condition. In addition, the Referee set aside the insurer's "back-up" denial of claimant's claim for a cervical strain.

On review, claimant objects to the insurer's oral amendment of the November 10, 1992 partial denial at hearing. Claimant further argues that the denial is invalid since it is a prospective denial of all future medical treatment in the claim.

Propriety of the November 10, 1992 Denial

The November 10, 1992 denial provided, in pertinent part:

> "* * * based on the medical information received to date, the condition diagnosed as osteophytes did not arise out of, nor in the course and scope of your employment. Therefore, the surgical procedure to remove the osteoarthritic spur and any subsequent treatment thereafter, is not a part of the accepted cervical strain and I must advise you, without waiving other potential defenses, that we are denying the osteophytectomy performed on 9/10/92, and all treatment beyond 9/9/92." (Emphasis supplied).

At hearing, the Referee allowed the insurer to amend its denial to deny only medical treatment beyond September 9, 1992 which was not medically related to the cervical strain. Claimant objected to amendment of the denial and continues to assert his objection on Board review. Specifically, claimant argues that the insurer is precluded from orally amending its denial at hearing. Claimant relies on Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993), where the court held that employers are bound by the express language of their denials.

We addressed a similar argument in Judith M. Morley, 46 Van Natta 882 (1994). In that case, an insurer denied the claimant's wrist/forearm condition on the grounds that the claim was untimely filed. The claimant contended, based on the court's holding in Tattoo, that the insurer was bound by the language of its denial and could not contest the merits of the claimant's current condition claim since that basis was not raised by the denial. On Board review in Morley, we held that because the parties tried the compensability issue by implicit agreement (i.e., without objection), the issue of compensability of the left wrist/forearm condition was properly before the Referee for consideration.

In the present case, claimant objected to the insurer's oral amendment of the denial and continues to assert his objection on Board review. Thus, this case is distinguishable from Morley where no objection was raised by the claimant to proceeding on a basis not raised by the denial. See also Lloyd L. Crockett, 43 Van Natta 1767 (1991) (holding that oral amendment of a denial should have been allowed where the claimant did not object). Inasmuch as claimant did not waive his objection, we conclude that it was error for the Referee to consider the amended denial. See William S. Peckham, 46 Van Natta 926 (1994) (because the claimant did not object, the Board treated an insurer's surgery denial as a denial of surgery for a torn medial meniscus, rather than surgery for calcification of the medial meniscus, as the denial had expressly stated). Accordingly, we address claimant's contention that the written denial is prospective and, therefore, invalid.

An employer may deny a specific unpaid claim or a current claimed need for treatment, but may not deny its future responsibility relating to an accepted claim. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, the insurer's denial partially denied claimant's osteophytectomy surgery as not related to the compensable injury. This is a procedurally valid partial denial of claimant's current need for treatment for osteophytes. However, the denial also purports to deny "all treatment beyond 9/9/92." Such a denial of future care is invalid and of no effect since it attempts to deny benefits for any disability resulting from the injury that gave rise to the accepted claim. Boise Cascade Corp. v. Hasslen, 108 Or App 605, 607 (1991).

Consequently, we set aside that portion of the insurer's denial which prospectively denied claimant's medical treatment for a cervical strain. We now turn to the merits of the procedurally valid portion of the denial (that portion of the denial which denies that claimant's osteophytectomy surgery is compensably related to the accepted injury).

Compensability of Osteophytectomy Surgery

We adopt the reasoning and conclusions of the Referee which upheld the insurer's denial of claimant's osteophytectomy surgery and treatment related to the surgery.

Claimant is entitled to an assessed attorney fee for prevailing over the prospective portion of the November 10, 1992 denial (which denied treatment for claimant's compensable cervical strain condition after September 9, 1992). ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the prospective portion of the denial is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs, and claimant's counsel's statement of services, as well as the insurer's objections), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated October 29, 1993 is affirmed in part and reversed in part. That portion of the Referee's order that upheld the insurer's November 10, 1992 denial in its entirety is reversed. The portion of the denial which denied responsibility for "all treatment beyond 9/9/92" is set aside as prospective. The remainder of the Referee's order is affirmed. For services at hearing and on Board review with regard to the prospective portion of the denial, claimant's attorney is awarded $1,200, payable by the insurer.

Board Member Westerband specially concurring.

I agree fully with the lead opinion and write separately to further discuss the purpose and impact of the court's holding in Tattoo v. Barrett Business Service, supra.

Tattoo was not a "pleading and practice" case. Rather, the court addressed the merits of claimant's contention that the insurer's denial was unlawful for being prospective. In essence, the court said that if a denial is overbroad for being prospective, the insurer will not be permitted to come into the hearing and amend the denial retroactively to eliminate the illegal taint; that, upon issuance of a prospective denial, the damage has already been done, and the illegality has already occurred. Therefore, when the lawfulness of the terms of the denial is at issue, the insurer is bound by the terms of the denial, for better or for worse.

In so holding, the court did not mean to suggest that a denial could not be amended at hearing, pursuant to the Board's "pleading and practice" rules, for the purpose of raising new issues or eliminating defenses to a claim for compensation. Tattoo was not a "pleading and practice" case.

Board Member Haynes dissenting.

Because I believe that the Referee was correct in allowing oral amendment of the denial at hearing, I respectfully dissent.

The Board's rules provide that amendments are freely allowed up to the date of the hearing. OAR 436-06-031. If a new issue is raised at the hearing, the referee may continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue and a continuance is necessary to allow the party an opportunity to cure the surprise and prejudice. Id. Consistent with the Board's rules, the existing case law permits oral amendments of denials provided that a claimant may obtain a continuance on the basis of surprise or prejudice. See, e.g., Terry R. Surratt, 45 Van Natta 1207 (1993); Marsha K. Flanary, 44 Van Natta 393 (1992); Lloyd L. Crockett, 43 Van Natta 1767 (1991).

Here, claimant's only basis for objecting to an amendment of the denial is surprise or prejudice resulting from a new and different basis raised by the insurer for denying the claim. A continuance would have remedied any surprise or prejudice caused by the amendment since it would have allowed further investigation and development of the record if this was necessary.

Moreover, allowing oral amendment of the denial in this case would not have caused claimant any prejudice or surprise. Whether or not amendment of the denial is allowed, the issue in this case is the same: whether the osteoarthritic spur and treatment for that condition is compensably related to the accepted cervical strain condition. The only change in the compensability issue that would be caused by amendment of the denial is that the compensability of future medical treatment for the accepted cervical strain would no longer also be at issue.

Under existing Board precedent, oral amendments of denials are allowed subject to the claimant's right to a continuance. In Donna J. Wilson, 42 Van Natta 1026 (1990), the claimant objected to oral amendment of a denial at hearing, but did not seek a continuance on the basis of surprise or prejudice. On review, we noted that the remedy provided by our rules was a continuance to cure any surprise or prejudice which resulted from the amendment. Since the claimant did not move for a continuance and elected to proceed instead, we concluded that she waived her objection to the oral amendment. Id. at 1027.

Here, as in Wilson, claimant has objected to the amendment of the denial, but has not requested a continuance. In fact, although the Referee raised the possibility of a continuance to cure any surprise caused by the amendment of the denial, claimant did not request a continuance on this basis. (Tr. 8). By declining a continuance to remedy any surprise or prejudice (assuming any existed), claimant waived his objection to the amendment and elected to proceed on the record as developed and litigate the issues raised. Because claimant elected not to request a continuance and proceeded with the hearing, I would conclude that he agreed to litigate the issues raised by the amended denial. Donna J. Wilson, supra.[1]

Citing Tattoo v. Barrett Business Service, 118 Or App 348 (1993), claimant contends that the insurer is precluded from orally amending its denial at hearing. In Tattoo, the Board held that a carrier's denial of "current chiropractic care" was not prospective. Before the court, the claimant contended that the carrier's denial was impermissibly prospective. In support of this contention, the claimant pointed to testimony of the claims examiner that she meant to deny past and future treatment and believed that it would be unnecessary to issue subsequent denials of future treatment. In rejecting the claimant's contention, the court held that employers are bound by the express language of their denials and that the testimony of the claims examiner concerning her intent in issuing the denial was irrelevant.

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[1] The practice of allowing oral amendments to denials subject to the claimant's right to a continuance is consistent with the goals of the workers' compensation system since it reduces litigation by allowing all issues to be decided in one proceeding. See ORS 656.012(2)(b).

Tattoo held that a party cannot offer testimony which interprets a denial in a manner contrary to its express language. The issue of whether a carrier may orally amend its denial at hearing was not before the court and was not decided by the court. Thus, the holding in Tattoo is inapposite here and does not preclude oral amendments to denials.

In any case, the court's holding in Tattoo is not inconsistent with existing Board case law which allows a carrier to orally amend a denial. In this regard, the Tattoo court was concerned that if it were to allow testimony concerning an employer's intent in issuing a denial, an employer could change what it had expressly said in a denial to the detriment of all parties who have relied on the language. Id at 352. As previously noted, the cases allowing oral amendments address this concern by allowing the remedy of a continuance to cure any surprise or prejudice which results from altering the basis for a denial. Thus, Tattoo is consistent with the cases allowing oral amendments: employers are bound by the express language of their written denials unless orally amended at hearing (subject to the claimant's right to a continuance to further develop the record on the amended basis for the denial).

Although I would affirm the Referee's conclusion that claimant's osteophytectomy surgery and treatment related to the surgery is not compensable, I would nonetheless find that claimant is entitled to a reasonable assessed fee for services concerning clarification of the denial. See Marsha K. Flanary, supra at 394. Here, the insurer's denial purported to deny "all treatment beyond 9/9/92." Such a denial of future care is invalid and of no effect since it attempts to deny benefits for any disability resulting from the injury that gave rise to the accepted claim. Boise Cascade Corp. v. Hasslen, supra at 607. Thus, claimant is entitled to an assessed attorney fee to the extent that the insurer's denial denied compensability of future medical treatment for the accepted cervical strain. See ORS 656.386(1).

For the foregoing reasons, I disagree with the majority's broad interpretation of the Tattoo holding and conclude that oral amendment of the denial was proper.

In the Matter of the Compensation of
HELEN J. BOHNENKAMP, Claimant
WCB Case No. 93-04745
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
SAIF Legal Department, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Peterson's order that: (1) set aside its denial of claimant's current cervical condition; (2) found that the Hearings Division lacked jurisdiction to address the reasonableness and necessity of claimant's proposed medical treatment; (3) set aside a Notice of Closure as prematurely issued; and (4) concluded that the aggravation issue was moot in light of his finding that the claim was prematurely closed. Claimant cross-requests review of that portion of the Referee's order that found that the Hearings Division lacked jurisdiction to address the reasonableness and necessity of claimant's proposed medical treatment. In the event we find the record insufficiently developed concerning the reasonableness and necessity of claimant's surgery, claimant moves to remand for the taking of additional evidence. The issues are compensability, jurisdiction, premature closure, aggravation and remand. We decline to remand, affirm in part, reverse in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

In its March 16, 1993 denial, SAIF denied claimant's current need for treatment and proposed surgery on the grounds that the major contributing cause of claimant's current condition was her preexisting degenerative disc disease rather than the compensable injury. (Ex. 29).

At hearing, SAIF indicated that there were two separate issues concerning compensability of claimant's current condition and need for treatment. First, SAIF's counsel indicated SAIF was contending that claimant's degenerative disc disease and current condition and need for treatment were not causally related to the compensable injury. Second, SAIF also indicated that it was asserting that the proposed surgery and medical treatment was not reasonable and necessary medical treatment. (Tr. 3-4). SAIF contended that the Hearings Division did not have jurisdiction to decide the reasonableness and necessity issue. (Tr. 3).

In his order, the Referee determined that the Hearings Division did not have jurisdiction to address the reasonableness and necessity of claimant's proposed surgery and medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial of claimant's current cervical condition. However, the Referee found that the Hearings Division lacked jurisdiction to address the reasonableness and necessity of claimant's proposed medical treatment for her current cervical condition. The Referee also set aside a Notice of Closure as prematurely issued. In light of his finding that the claim was prematurely closed, the Referee concluded that the aggravation issue was moot.

Compensability of Claimant's Current Cervical Condition

We adopt the Referee's conclusions and reasoning concerning the compensability of claimant's current cervical condition with the following supplementation.

The Referee found, and we agree, that Dr. Grewe's is the most persuasive opinion concerning the causation of claimant's current condition.

Claimant has degenerative disease in her cervical spine which preexisted her April 10, 1989 industrial injury. Before the April 10, 1989 industrial injury, claimant was physically active and was involved in activities such as skiing, whitewater rafting and jogging. She had no prior problems with her neck or back and had been in generally good health. According to the medical evidence, claimant's preexisting condition became symptomatic because of the compensable injury. Since the April 10, 1989 industrial injury, claimant has been unable to engage in her usual athletic activities because of neck pain.

Dr. Grewe's opinion supports a conclusion that the April 10, 1989 industrial injury is the major contributing cause of claimant's current disabling symptoms from her preexisting degenerative joint disease. Where a work injury renders a preexisting condition symptomatic, the current condition is compensable so long as the compensable injury is the major contributing cause of the worker's resultant need for treatment. ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). Accordingly, based on Dr. Grewe's persuasive opinion, we conclude that claimant has established the compensability of her current condition and need for treatment.

Comparing Dr. Grewe's opinions in Exhibits 26 and 32, SAIF argues that Dr. Grewe changed his opinion without explanation. We disagree. We do not find Dr. Grewe's opinions in Exhibits 26 and 32 to be inconsistent or to amount to a changed opinion. In Exhibit 26, Dr. Grewe notes that the compensable injury did not cause claimant's preexisting degenerative disease, but that the preexisting condition has now become symptomatic causing persistent symptoms. In Exhibit 32, Dr. Grewe explains that the major cause of claimant's disabling symptoms from the degenerative disease is her compensable injury.

ORS 656.005(7)(a)(B) only requires that claimant establish that the compensable injury is the major contributing cause of the disability or need for treatment. U-Haul of Oregon v. Burtis, supra. Here, claimant has satisfied that burden. Having found claimant's current condition compensable, we now address the reasonableness and necessity of the medical treatment proposed by Dr. Grewe.

Compensability of Proposed Medical Treatment

The Referee found that the Hearings Division lacked jurisdiction to address the appropriateness of the medical treatment proposed by Dr. Grewe. Dr. Grewe has proposed surgery at C3-4 or, alternatively, a trial with an epidural stimulator.

Subsequent to the Referee's order, the court issued its decision in Jefferson v. Sam's Cafe, 123 Or App 464 (1993). In Jefferson, the court held that ORS 656.327, which provides a procedure for Director review of medical services disputes, is inapplicable to disputes regarding proposed medical treatment. The Jefferson court concluded that since ORS 656.327 does not apply to future medical treatment, the Board and its Hearings Division have exclusive jurisdiction to resolve disputes concerning proposed medical treatment. Accordingly, we have jurisdiction to address the appropriateness of claimant's proposed medical treatment.

Here, three physicians, including claimant's treating physician, have submitted reports which address the reasonableness and necessity of claimant's proposed medical treatment. Thus, we conclude that the record has been fully developed concerning this issue. Inasmuch as we find the record completely developed concerning the reasonableness and necessity of the proposed medical treatment, we find it unnecessary to remand to the Referee for additional evidence taking and we proceed with our review.

Claimant is entitled to medical services for conditions resulting from the compensable injury "for such period as the nature of the injury or the process of recovery requires." ORS 656.245. Claimant carries the burden of proving by a preponderance of the evidence that the proposed surgery is reasonable and necessary. West v. SAIF, 74 Or App 317 (1985).

Three physicians give opinions concerning the reasonableness and necessity of the surgery or trial with an epidural stimulator. Dr. Seres examined claimant on behalf of SAIF. He did not feel that claimant would benefit significantly from the proposed surgery at the C3-4 level; he explained that claimant's pain complaints went beyond those which could be explained by narrowing of the neural foramen in the cervical canal at the C3-4 level on the left. (Ex. 14-5). Dr. Seres opined that immobilization of a single joint level, as proposed by Dr. Grewe, might have some temporary benefit, but would not result in an overall improvement in the economy and function of the spine. Dr. Seres also opined that claimant was not a good candidate for an epidural stimulator. (Ex. 34-2).

Dr. Quarum reviewed claimant's records for SAIF. Dr. Quarum believed that there was no indication of nerve root impingement at the C3-4 level and that there were no objective findings showing that the proposed surgery was medically indicated or appropriate. (Ex. 20-5). He felt, based on Dr. Holt's psychiatric evaluation of claimant, that claimant had a predisposition for symptom magnification. On this basis, Dr. Quarum believed that the possibility of a failed surgery was very high. Dr. Quarum also opined that an epidural stimulator had been shown to be effective for radicular pain of an organic nature which claimant did not have. Thus, he opined that the epidural stimulator was not indicated in claimant's case. (Ex. 33-3).

Dr. Grewe, a neurosurgeon, has treated claimant for three years. Because claimant has not responded to conservative treatment measures, he has proposed anterior discectomy and interbody fusion, with removal of osteophytes at the C3-4 level. Dr. Grewe noted that a myelogram demonstrated stenosis and encroachment from an osteophyte at the neural foramen at C3-4 on the left with some transverse bar formation. Dr. Grewe believes that claimant's current symptoms are coming from the C3-4 level. He explained that clinical findings are usually vague at this level of the spine since it is above the distribution for the upper extremities and, therefore, there are no reflex changes or muscle atrophy. Dr. Grewe believes that immobilizing the joint and making more room for the nerve roots should provide relief for the symptoms generated from the C3-4 level. (Ex. 32). Dr. Grewe also believes that the pain and resultant muscle contraction is the major cause of symptoms referable to claimant's cranial nerves and the axial symptoms extending from the cervical spine to the area between the shoulder-blades. Dr. Grewe explained that claimant has other symptoms which are part of the upper cervical syndrome, such as a sense of vision being out of focus, ligtheadedness, dizziness, headache, a sense of fatigue, stiffness and pain with movement. Dr. Grewe has opined that such symptoms usually disappear if the pain can be eliminated from the pain generator. Dr. Grewe alternatively proposed a trial with an epidural stimulator, if surgery was not approved, to manage the C3-4 symptoms.

We generally give greater weight to the opinion of the treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to rely on Dr. Grewe's opinion that surgery or trial with the epidural stimulator is appropriate medical treatment for claimant's compensable condition. Thus, based on his opinion, we conclude that the proposed medical treatment is reasonable and necessary.

Claimant is entitled to an assessed attorney fee for prevailing on the issue of compensability of proposed surgery and medical services. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the medical services issue is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, and the value of the interest involved.

Jurisdiction/Premature Closure/Aggravation

The Referee set aside the March 17, 1993 Notice of Closure as premature. On review, SAIF contends that since an Order on Reconsideration had not issued at the time of the hearing, the Referee lacked jurisdiction to address this issue. We agree.

The Hearings Division does not have jurisdiction to consider a request for hearing on a Determination Order or Notice of Closure prior to the issuance of a reconsideration order. See David Hill, 46 Van Natta 526 (1994); Larry R. Hudnall, 44 Van Natta 2378 (1992). Accordingly, we vacate that portion of the Referee's order which purported to set aside the Notice of Closure.

Both parties request that we take administrative notice that the Department issued an Order on Reconsideration on September 27, 1993 (after the date of hearing) which rescinded the March 17, 1993 Notice of Closure. We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders. See Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Accordingly, we take administrative notice of the September 27, 1993 Order on Reconsideration. Because the aforementioned reconsideration order set aside the March 17, 1993 Notice of Closure, the claim remains open. Thus, the aggravation issue is moot.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 2, 1993, as reconsidered on October 12, 1993, is reversed in part, vacated in part and affirmed in part. SAIF's denial of claimant's proposed medical treatment, including surgery, is set aside and the claim is remanded to SAIF for processing according to law. That portion of the Referee's order that set aside the March 17, 1993 Notice of Closure is vacated. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the medical services issue, claimant is awarded $1,500, payable by SAIF. For services on Board review, claimant is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
LORI L. CHURCH, Claimant
WCB Case No. 93-06330
ORDER ON REVIEW
Jim B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant, pro se, requests review of Referee Davis' order that upheld the SAIF Corporation's denial of her upper and lower back injury claim and the worsening of her anxiety and fibromyalgia conditions. In her brief, claimant requests remand for a new hearing on the basis that her attorney inadequately represented her by failing to contact her witnesses. On review, the issues are motion to remand and compensability. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

In her appellant's brief, claimant requests a new hearing on the grounds that her attorney inadequately represented her by failing to contact her witnesses. We treat claimant's request as a motion to remand for additional evidence.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

By claimant's own assertion, the testimony she seeks to submit into evidence was obtainable at the time of hearing. Claimant alleges that she was not informed until the morning of the hearing that her attorney failed to contact her witnesses. When evidence was obtainable, allegations of inadequate representation, by itself, is insufficient to merit remand. See Diane E. Sullivan, 43 Van Natta 2791, 2792 (1991). Furthermore, with regard to the adequacy of claimant's representation, we note that the Workers' Compensation Board is not the proper forum for determining that issue. Id. We are unable to find that the evidence claimant now seeks to produce was not obtainable with due diligence at the time of hearing. Accordingly, the motion for remand is denied.

Compensability

We adopt and affirm the Referee's opinion on this issue.

ORDER

The Referee's order dated October 26, 1993 is affirmed.

August 3, 1994 Cite as 46 Van Natta 1591 (1994)

In the Matter of the Compensation of
LEE A. HARRIS, Claimant
WCB Case No. 93-03036
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Davis' order that upheld the self-insured employer's "current condition" denial of claimant's low back condition. On review, the issue is the procedural validity of the denial. We reverse.

FINDINGS OF FACT

Claimant was a skoog operator at the employer. On December 7, 1992, claimant slipped on some veneer. She experienced an immediate onset of pain in the buttocks and sacroiliac region. (Exs. 2 and 6).

Claimant was in her second trimester of pregnancy at the time of the injury. She was treated at an emergency room, where Dr. Rennick diagnosed acute lumbosacral strain. He also noted irregular contractions since the fall. He referred claimant to her family doctor, Dr. Jeppesen, for further treatment of her back pain and notified Dr. Ihara, claimant's obstetrician, of the injury. (Exs. 1-6).

On December 9, 1992, Dr. Ihara released claimant to light duty work for two hours a day. (Ex. 5).

On February 16, 1993, Dr. Jeppesen wrote to the employer as follows:

"This is in reply to your letter dated February 9, 1993. This is indeed a unique problem to determine what part of [claimant's] continuing disability is due to her on the job injury and which part is due to her near term pregnancy. Perhaps the most difficult part in her treatment is not being able to use medications which would ordinarily accelerate her healing and resolution of symptoms because of the pregnancy. In addition being restricted in the use of x-ray in evaluation of her low back because of her pregnancy.

"Specifically, in reply to your question about what would the normal recovery period or at least average recovery for this type of injury would be about three to four weeks of time loss and then lighter work for an additional month to six weeks and then medical stationary status in about three weeks. At this time, I would estimate that no more than 50% of her disability is due to her injury with the rest being due to her near full-term pregnancy." (Ex. 14).

On February 19, 1993, the employer accepted claimant's condition as a sacrococcugeal strain. (Ex. 15A). On the same date, it issued a denial which stated:

"Medical information in our file shows that your compensable injury no longer remains the major contributing cause of your disability or need for medical treatment. Our inquiry to and response from Dr. Jeppesen indicates that your continuing need for disability and medical treatment is due, in major part, to your near full-term pregnancy. Accordingly, pursuant to ORS 656.005(7)(a)(A), we are hereby denying your claim for continuing disability and medical treatment." (Ex. 15).

Claimant delivered her baby. On April 15, 1993, Dr. Ihara predicted that claimant would be able to return to work on May 3, 1993. (Ex. 17).

On April 29, 1993, claimant sought treatment for increasing low back and left leg pain from Dr. Black. (Ex. A).

The employer had not closed claimant's claim prior to issuing the denial.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's low back strain combined with her pregnancy to prolong disability and the need for medical services. Applying ORS 656.005(7)(a)(B), the Referee concluded that claimant's injury was no longer the major contributing cause of claimant's current disability and need for treatment and, accordingly, upheld the employer's "current condition" denial.

On review, claimant first contends that the Referee erred in deciding the case under ORS 656.005(7)(a)(B), when the employer specifically cited ORS 656.005(7)(a)(A) as the basis for its denial. Second, claimant contends that, whether or not her injury combined with her pregnancy, she was procedurally entitled to continued benefits based on the compensable injury.

Employers are bound by the express language of their denials. Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993). Because the employer accepted a condition at the same time it issued its denial, we interpret the employer's letter to be a "partial denial." See Johnson v. Spectra Physics, 303 Or 49, 58 (1987) (the insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies). Thus, if a carrier denies a portion of a claim, it must do so clearly and with specificity. Weyerhaeuser v. Warrilow, 96 Or App 34, 38 (1989) (partial denial of "degenerative changes with mild osteophytic spurring" was sufficiently specific). Furthermore, while an accepted claim is in open status, a carrier may issue a partial denial of an unrelated condition. Tattoo v. Barrett Business Service, supra.

Here, the employer partially denied claimant's claim for continuing disability and medical treatment for her low back, on the basis that such disability and medical treatment were due in major part to her pregnancy. We conclude that this denial is procedurally invalid for two reasons.[1]

First, the denial does not specify that it is partially denying an unrelated condition. Instead, it is denying future disability and medical treatment for claimant's accepted condition. Such a denial is an invalid prospective denial of future responsibility for an accepted claim. See Green Thumb, Inc. v. Basl, 106 Or App 98 (1991) (a denial is not impermissibly prospective where it denies benefits for a current need for medical treatment and does not preclude future benefits); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989) (an employer may not deny its future responsibility for payment of benefits relating to a previously accepted claim, unless it follows the statutory procedure for claim closure); Roller v. Weyerhaeuser Co., 67 Or App 583 (1984) (an employer may not terminate future responsibility for a claim before the extent of claimant's disability has been determined).

Second, claimant's accepted low back claim was still in open status when the denial issued. Thus, even if claimant experienced a "resultant condition" due to the combination of the injury and her preexisting pregnancy, and the employer's denial is interpreted as a "current condition" denial pursuant to ORS 656.005(7)(a)(B), it is a procedurally improper denial.

Subsequent to the Referee's order and the briefing on review in this matter, the Court of Appeals issued its decision in United Airlines, Inc. v. Brown, 127 Or App 253 (1994), in which it held that a carrier's preclosure "resultant condition" denial under ORS 656.005(7)(a)(B) is not procedurally valid where the claim has not first been closed. The court affirmed a Board order holding that a carrier's "resultant condition" denial under ORS 656.005(7)(a)(B) did not entitle the carrier to discontinue payment of the claimant's temporary disability benefits while the claim was in open status. The carrier argued that, because the claimant's preexisting degenerative disease was the major contributing cause of her current disability, its denial was procedurally valid. The court disagreed, finding nothing in the text or context of ORS 656.005(7)(a)(B) to suggest that the legislature intended that provision to provide carriers with the procedural authority to deny accepted claims. Id. at 257.

Consequently, the Brown court held that, if a carrier determines that a compensable injury is no longer the major contributing cause of a worker's disability or need for treatment, the appropriate procedure is claim closure under ORS 656.268. Id.; see also Jean K. Elliott-Moman, 46 Van Natta 991 (1994) (applying Brown). See also John M. Lampman, 46 Van Natta 1184 (1994), in which we disavowed our analysis in Daniel R. Bakke, 44 Van Natta 831 (1992), which had permitted a partial denial of compensation for a then-current resultant condition.

Claimant is entitled to an assessed attorney fee for prevailing on the denial issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the denial issue is $3,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 22, 1993 is reversed. The self-insured employer's denial is set aside. The claim is remanded to the employer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the employer.

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[1] As claimant pointed out in her arguments at hearing, a pregnancy cannot be a consequential condition unless the industrial injury caused the injured worker to suffer complications of pregnancy. Neither party made such a contention here. Consequently, we do not address claimant's argument that the Referee erred in deciding the case under ORS 656.005(7)(a)(B), when the employer specifically cited ORS 656.005(7)(a)(A) as the basis for its denial.

In the Matter of the Compensation of
FRANCIS A. SIMS III, Claimant
WCB Case Nos. 93-02067 & 92-15231
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Referee Hazelett's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) upheld the Lumbermen's Underwriting Alliance's (LUA) denial of claimant's "new injury" claim for the same condition; (3) found that SAIF had improperly recalculated claimant's temporary total disability (TTD) rate; and (4) assessed an attorney fee pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable recalculation of claimant's TTD rate. LUA cross-requests review of that portion of the order that: (1) admitted Exhibits 28 and 30 into evidence; (2) found that LUA had denied compensability of, in addition to responsibility for, claimant's claim; and (3) assessed penalties or, in the alternative, attorney fees for LUA's allegedly unreasonable compensability denial. On review, the issues are evidence, responsibility, rate of TTD, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing and on review, LUA objected to the Referee's admission of Exhibit 28, which consists of: (1) an unsigned, undated "check-the-box" response to a letter from SAIF's attorney to Dr. Stahl, claimant's treating physician; (2) an affidavit from Ms. Meyer, a legal assistant with SAIF, explaining the circumstances surrounding the sending and receipt of the "check-the-box" opinion; and (3) a copy of a courier's invoice relating to a delivery to Dr. Stahl. LUA objected to this exhibit on the basis that Exhibit 28-3 was unauthenticated and Exhibits 28-1 and 28-2 were hearsay and irrelevant. The Referee admitted Exhibit 28, noting the the fact that Exhibit 28-3 was unauthenticated would go to the weight and explaining that Exhibits 28-1 and 28-2 had some relevance as to the manner of the receipt of Exhibit 28-3. (Tr. 6-7).

In addition, the Referee noted that, since the record was already being held open for seven days to allow claimant and SAIF to submit wage information, he would allow SAIF to submit documentation authenticating Exhibit 28-3 within that same seven-day period. That documentation was timely submitted as Exhibit 30.

ORS 656.283(7) provides that a referee is not bound by common law or statutory rules of evidence *** and may conduct a hearing in any manner that will achieve substantial justice. The statute has been interpreted to give referees broad discretion in the admission of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). We review the Referee' evidentiary rulings for abuse of discretion. Evan I. Lyman, II, 45 Van Natta 2301 (1993); William J. Bos, 44 Van Natta 1691 (1993).

The Referee did not abuse his discretion in admitting Exhibit 28. As the Referee noted, the fact that Exhibit 28-3 was not authenticated went to its weight, not its admissibility. Shirlene E. Volcay, 42 Van Natta 2773 (1990). Furthermore, as the Referee ruled at hearing, the remaining portions of Exhibit 28 had some relevance.

Regarding the admission of Exhibit 30, which consists of an affidavit from Dr. Stahl stating that he made the check marks on Exhibit 28-3 and restating the opinion contained in Exhibit 28-3, we adopt the Referee's reasoning and conclusions.

Responsibility

At hearing, both insurers agreed that claimant's current low back condition was compensable but that the responsibility issue remained in dispute. Relying on SAIF v. Drews, 117 Or App 596 (1993), the Referee concluded that responsibility remained with SAIF because, as the last insurer with an accepted claim regarding claimant's low back condition, SAIF had not established that an injury involving the same condition during a later employment was a material contributing cause of claimant's subsequent disability or need for treatment. In reaching this conclusion, the Referee relied on the opinion of Dr. Rich, who examined claimant on behalf of LUA.

We adopt the Referee's reasoning and conclusions that claimant's current low back condition involves the "same condition" as the condition for which SAIF has an accepted claim. Therefore, we agree that ORS 656.308(1) is applicable to this claim. However, subsequent to the Referee's order, the Supreme Court issued its decision in SAIF v. Drews, 318 Or 1 (1993). The Court ruled that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). Thus, to shift responsibility, SAIF must show that claimant's employment activities on September 22, 1992 were the major contributing cause of claimant's disability or need for treatment. ORS 656.308(1); Drews, supra; Gary Wallace, 46 Van Natta 258 (1994)

Here, the change in the standard of proof does not change the outcome of the responsibility issue. For the reasons stated in the Referee's order, we find the opinion of Dr. Rich to be the most persuasive. Based on Dr. Rich's persuasive opinion, the major contributing cause of claimant's current low back condition is his accepted January 24, 1992 injury at SAIF's insured, not the September 22, 1992 incident at LUA's insured. (Ex. 27-4). Accordingly, SAIF remains responsible for claimant's current low back condition.

Penalties For LUA's Unreasonable Compensability Denial

At hearing, the Referee determined that both LUA and SAIF had denied compensability as well as disclaiming responsibility. Both insurers amended their denials at hearing to include only disclaimers of responsibility. (Tr. 11-13). The Referee found the compensability denials unreasonable and assessed penalties against each insurer in the amount of 25 percent of the amounts "then due" as of the date of hearing. In the event that there were no amounts "then due," the Referee alternatively assessed separate attorney fees against the insurers for unreasonable resistance to payment of benefits. At hearing and on review, LUA argues that its November 11, 1992 denial disclaimed responsibility only and was not a denial of compensability.

With the following supplementation, we adopt the Referee's reasoning and conclusions regarding the issues of whether LUA's denial included an unreasonable compensability denial and the appropriateness of a penalty, or alternatively an assessed attorney fee if no amounts were "then due" at hearing upon which to base a penalty.

In Johnny M. Davis, 45 Van Natta 2282 (1993), we concluded that the carrier had denied compensability as well as disclaimed responsibility. We based our conclusion on the fact that, although the carrier had requested a "307" order, its "disclaimer" stated that it was not waiving other issues of "compensability" and it included "notice of hearing" provisions consistent with a denial of compensation pursuant to OAR 438-05-053(4). Specifically, its "disclaimer" stated that "[t]his is a denial of your claim for benefits."

Here, although LUA's "disclaimer" did not state that it was not waiving other issues of "compensability," it included "notice of hearing" provisions consistent with a denial of compensation pursuant to OAR 438-05-053(4) and stated that "[t]his is a denial of your claim for benefits." (Ex. 17). In addition, LUA did not request designation of a paying agent pursuant to ORS 656.307.

The Referee found that his conclusion that LUA denied compensability was supported by statements on LUA's 1502 form indicating that the claim was denied and responsibility was disclaimed. (Ex. 19). LUA argues that the Referee should not have resorted to documents outside of the denial to determine the denial's meaning. We note that the court has held that employers are bound by the express language of their denials and testimony as to a claims examiner's intent in issuing a denial is irrelevant. Tattoo v. Barrett Business Service, 118 Or App 348 (1993). However, we need not go outside LUA's denial to interpret its meaning. As noted above, by its express language, the denial stated that it was "a denial of [claimant's] claim for benefits."

LUA also argues that the Referee's assessment of a 25 percent penalty against each insurer for its respective unreasonable compensability denial creates a penalty in excess of that allowed by ORS 656.262(10)(a). We disagree. ORS 656.262(10)(a) allows a maximum penalty of 25 percent to be assessed against a single insurer or self-insured employer, but it does not prohibit the assessment of a penalty against each insurer or employer for separate unreasonable conduct even though that insurer or employer is not responsible for the claim. William W. Clunas, 45 Van Natta 2234 (1993); Alfred M. Norbeck, 35 Van Natta 802, 804 (1983), aff'd SAIF v. Norbeck, 70 Or App 270 (1984).

Rate of TTD

While claimant's claim with SAIF was in open status, SAIF paid claimant's TTD based on the information provided by the employer on the 801 form. However, subsequently, SAIF recalculated the TTD rate based on unemployment documents, which resulted in a lower TTD rate. The Referee found that SAIF had improperly recalculated claimant's wage rate. We adopt the Referee's reasoning and conclusions regarding the issue of the rate of TTD with the following supplementation.

In Qualified Contractors v. Smith, 126 Or App 131 (1994), the court affirmed the Board's decision that the intent of the worker and employer at the time of hire was established by the information provided by the employer on the 801 form and testimony at hearing. There, the 801 form stated that the claimant worked 12-hour shifts, seven days a week. The claimant testified that, when he was working, he was expected to work 12-hour shifts, seven days a week. Based on that evidence, even though there were extended gaps in claimant's employment with the employer, the court found that, when the claimant was working for the employer, he was employed for 12-hour shifts, seven days a week.

Here, as in Smith, supra, the 801 form filled out by the employer and the testimony at hearing establish the parties' intent at the time of hire. Here, the 801 form completed by the owner of the company stated that claimant worked five days per week, eight hours per day, at $8.00 per hour. (Ex. 5). Both claimant and the employer testified that, weather permitting, claimant maintained that schedule, although claimant was not paid for the time he was unable to work due to the weather. (Tr. 19, 55). Thus, even though there were periods claimant could not work due to the weather, the parties' intent at the time of hire was for claimant to work 40 hours per week. On this evidence, we agree with the Referee's conclusion that claimant's correct weekly wage rate for calculating TTD is $320 (40 hours per week x $8.00).

Penalties for SAIF's Alleged Unreasonable Recalculation of Claimant's TTD Rate

The Referee assessed an attorney fee pursuant to ORS 656.382(1) for SAIF's unreasonable resistance to payment of compensation in recalculating claimant's TTD rate and seeking an reduction in claimant's rate of compensation. On review, SAIF argues that claimant withdrew this attorney fee issue at hearing and that it is improper for the Referee to decide an issue not placed before him by the parties. We agree with SAIF.

The record reveals that, while claimant initially raised the issue of an attorney fee relating to SAIF's recalculation of his TTD rate at a lower rate based on unemployment documents, he withdrew that issue at hearing. (Tr. 10). Under those circumstances, we conclude that claimant waived that attorney fee issue and, consequently, the Referee lacked authority to decide that issue. See Nikki Burbach, 46 Van Natta 265, 268 (1994); Kathy K. Mason, 43 Van Natta 679 (1991); Theodore W. Lincicum, 40 Van Natta 1760 (1988), aff'd mem 100 Or App 100 (1989), but see Liberty Northwest v. Alonzo, 105 Or App 458 (1991).

Accordingly, we vacate that portion of the Referee's order that assessed an attorney fee against SAIF for its allegedly unreasonable recalculation of the TTD rate.

Attorney Fees on Review

Although compensability was not raised as an issue on review, it was an issue at hearing. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Consequently, claimant is entitled to an assessed fee for the services of his attorney on review. ORS 656.382(2).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's statement of services), the complexity of the issues, and the value of the interest involved. We note that, inasmuch as attorney fees and penalties are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the Referee's attorney fee and penalty awards regarding LUA's unreasonable compensability denial. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Benjamin G. Parker, 42 Van Natta 2476 (1990).

ORDER

The Referee's order dated July 30, 1993 is affirmed in part and reversed in part. That portion of the order that awarded a $200 assessed fee against the SAIF Corporation for its allegedly unreasonable recalculation of claimant's temporary total disability rate is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by SAIF.

In the Matter of the Compensation of
HAROLD H. BRUCE, Claimant
WCB Case Nos. 93-02074 & 93-00555
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Howell's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for hearing loss; and (2) upheld the Medite Corporation's denial of his occupational disease claim for the same condition. On review, the issues are compensability and responsibility.

We adopt and affirm the Referee's order with the following supplementation.

At the time of the hearing, the Referee found that SAIF had conceded that claimant's hearing loss was compensable. On review, claimant argues that SAIF waived its right to contest compensability because it conceded compensability at the hearing.

In Castle & Cooke v. Alcantar, 112 Or App 392, 395 (1992), the court stated that a "concession of compensability only admits that a claimant's condition resulted from a work exposure. It does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment." Thus, although SAIF conceded the issue of compensability, it did not concede that claimant's condition was SAIF's responsibility.

ORDER

The Referee's order dated November 8, 1993 is affirmed.

In the Matter of the Compensation of
ORLEETA J. BURTON, Claimant
WCB Case No. 93-03146
ORDER ON REVIEW
J. Randolph Pickett, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Mills' order that upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability.

We adopt and affirm the Referee's order, with the following modification and supplementation.

The Referee concluded that claimant's low back injury was not established by medical evidence supported by objective findings. See ORS 656.005(7)(a). That conclusion was based on the insurer's medical examination reports, which revealed that claimant had no objective findings of a back injury and that she had considerable functional overlay. It was also based on evidence that, later on the day that claimant allegedly injured her back, she had engaged in horseplay without apparent difficulty and she had told a supervisor that back injuries are difficult to detect and to disprove. Claimant argues that, because several physicians diagnosed low back strain and reported that she had experienced back pain on palpation and decreased spinal ranges of motion, she has met that statutory "objective findings" requirement and, therefore, has proven the compensability of her low back condition. We disagree.

Claimant saw several physicians for her alleged back injury, which supposedly occurred during an incident at work on December 15, 1992. She was diagnosed with low back strain based on her complaints of back pain, and physical findings of pain on palpation and decreased spinal ranges of motion.

On December 24, 1992, claimant treated with Dr. Toliver. On the basis of claimant's subjective complaints, decreased spinal range of motion and tenderness on paravertebral palpation, Toliver diagnosed cervical, thoracic and lumbar strain. (Ex. 8-1). However, he noted:

> "[Claimant] escalates pain symptoms out of proportion to the apparent injury. She has poor eye contact and acts as if she is in extreme pain. She sheds tears with maneuvers. Her behavior causes me to question how severe her injury really is.
>
> "* * * * *
>
> "* * * Please note that [claimant] was observed by an employee of this clinic to be moving about freely in the car, laughing and joking with friends, and was observed getting out of the car. However, as [claimant] was getting out of the car, she noticed that the employee was observing her and began to move about as if in extreme pain." (Ex. 8-1, -2).

Subsequently, claimant was examined by Drs. McKillop, orthopedic surgeon, and Dr. Rich, neurologist, on the insurer's behalf. They found no objective basis for claimant's injury claim; instead, they noted significant non-organic pain behavior and functional overlay. (Ex. 14-7, -8). Dr. Constien, another of claimant's treating physicians, concurred with Drs. McKillop's and Rich's report. (Ex. 15). Drs. McKillop and Rich later concluded that claimant did not sustain a back injury. (Ex. 16)

On this record, we conclude that significant doubt exists regarding whether claimant sustained a low back injury. We agree with claimant that the medical reports on which she relies do contain objective findings, e.g., pain on palpation and decreased spinal ranges of motion. See ORS 656.005(19). Nevertheless, in light of Dr. Toliver's December 24 chart note, and the examining physicians' conclusions (along with Dr. Constien's concurrence), which reveal that claimant had engaged in significant symptom magnification and other functional behavior, we conclude that those medical reports are unpersuasive. See Maximino Martinez, 45 Van Natta 1143 (1993) (initial medical report that did not take into account the claimant's significant symptom magnification discovered during subsequent examination held unpersuasive); Vincent A. Lopez, 44 Van Natta 29 (1992) (conclusory diagnosis of wrist sprain/strain held unpersuasive in view of subsequent reports that revealed no objective basis for the

claimant's complaints). This conclusion is supported by the evidence regarding claimant's horseplay and her statement to the supervisor concerning the difficulty of detecting and disproving back injuries. See Maria T. Galicia, 46 Van Natta 542, 543 (1994) (medical report based on history obtained from unreliable claimant lacked persuasive force).

For these reasons, we agree with the Referee that claimant has failed to establish that a compensable injury occurred.

ORDER

The Referee's order dated January 3, 1994 is affirmed.

In the Matter of the Compensation of
MELVIN L. SHROY, Claimant
WCB Case Nos. 93-07329 & 93-02639
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Bethlahmy's order that: (1) upheld the self-insured employer's denial of his aggravation claim for a 1990 low back condition; and (2) reversed the February 23, 1993 Order on Reconsideration (under a 1992 injury claim) that awarded claimant a 5 percent (6.75 degrees) scheduled permanent disability award for loss of sensation in his left foot. On review, the issues are aggravation and extent of scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with one exception. The Referee found that "The cause of claimant's decreased sensation on the medial aspect of the left foot is related to claimant's August 17, 1990 injury, not his April 17, 1992 injury." (O & O p. 3). The date of "August 17, 1990" should read "April 17, 1990."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had shown increased symptoms or a worsened underlying condition since the last arrangement of compensation with respect to his April 17, 1990 claim. Nevertheless, the Referee concluded that claimant did not establish a compensable aggravation of that claim because his claim for aggravation was not perfected and he did not show a diminishment of earning capacity.

The first question is whether claimant perfected an aggravation claim under ORS 656.273(3). To constitute an aggravation claim under that statute, the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened. Dennis Hutchinson, 46 Van Natta 539 (1994); Herman M. Carlson, 43 Van Natta 963, 964 (1991), aff'd on other grounds, Carlson v. Valley Mechanical, 115 Or App 371 (1992), rev den 315 Or 311 (1993). The report must establish a causal connection between claimant's noted condition and the compensable injury. Juan F. Carrizales, 43 Van Natta 2811 (1991).

Dr. Snodgrass, a neurologist, performed a medical arbiter examination on claimant on February 4, 1993. Dr. Snodgrass reported that claimant had "mild decreased sensation on the medial half of the left foot on both the dorsum and plantar aspects, which extends proximally to the level of the medial malleolus." (Ex. 39). In response to an inquiry from the employer's attorney, Dr. Snodgrass reviewed additional medical reports regarding claimant's April 17, 1990 claim which involved a herniated disc at L4-5. Dr. Snodgrass reported that a "disc at that level would be expected to impinge upon the L5 nerve root which supplies sensation to the medial part of the foot." (Ex. 42). Dr. Snodgrass concluded that that "the disc herniation at L4-5 which existed prior to the April 17, 1992 injury is a far more likely cause for the decreased sensation on the medial side of the foot, than was the strain of April 1992." (Ex. 42).

We conclude that Dr. Snodgrass' reports contain all the elements of a prima facie aggravation claim. Dr. Snodgrass reported that claimant had decreased sensation in his left foot and his later report established a causal connection between the noted condition and the 1990 compensable claim. Therefore, we conclude that the employer had notice that claimant's loss of sensation in his left foot was related to his accepted 1990 herniated disc claim.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the compensable condition. ORS 656.273(1). The Referee found that claimant had failed to establish a compensable aggravation because there was no evidence that the decreased sensation in his foot resulted in a diminishment of his earning capacity.

Diminished earning capacity is not a factor when a claimant has an alleged aggravation of a scheduled condition. In Fred Meyer, Inc. v. Farrow, 122 Or App 164, 167 (1993), the court held that aggravation of a scheduled injury is measured by increased loss of use. In the present case, claimant has an alleged aggravation of a scheduled condition and therefore, he must show that he is more disabled, i.e., that he has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. See Theodore W. Kinder, 46 Van Natta 391 (1994). A worsened condition is established by medical evidence supported by objective findings. ORS 656.273(1).

At the hearing, the employer conceded that claimant's left foot numbness was related to the April 1990 injury. (Tr. 6, 11). The employer argues, however, that claimant did not establish a worsened condition resulting from his accepted 1990 claim and that there is no proof that claimant had an increased loss of use of his left foot. We disagree.

The Referee found, and we agree, that claimant has shown increased symptoms or a worsened underlying condition since the last arrangement of compensation with respect to his April 17, 1990 claim. On October 8, 1991, Dr. McNeill reported that claimant was medically stationary and he stated that "[t]here is no diminished sensation in the region of his feet." (Ex. 18). As discussed above, Dr. Snodgrass reported on February 4, 1993 that claimant had mild decreased sensation in his left foot. (Ex. 39). Both Dr. Snodgrass and Dr. McNeill stated that claimant's loss of sensation in the left foot resulted from his April 1990 herniated disc. (Exs. 42 & 44).

We find that claimant has established a worsening of his compensable condition that resulted in an increased loss of use or function of his left foot. Therefore, we conclude that claimant has established a compensable aggravation.

The February 23, 1993 Order on Reconsideration that awarded claimant a 5 percent scheduled permanent disability award was issued with respect to claimant's April 17, 1992 injury. We agree with the Referee that claimant's loss of sensation in the left foot is not due to his April 17, 1992 injury. Therefore, we affirm the Referee's reversal of the Order on Reconsideration 5 percent award. By virtue of our compensability decision concerning claimant's aggravation claim, his April 17, 1990 claim will now be reopened. Claimant's extent of disability related to that claim will be addressed at the time of closure.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated October 13, 1993 is reversed in part. The self-insured employer's August 18, 1993 aggravation denial, as clarified on August 26, 1993, is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ZINAIDA I. MARTUSHEV, Claimant
WCB Case Nos. 93-11880, 93-11678 & 93-06337
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Neal's order which: (1) reduced claimant's 2 percent (3 degrees) scheduled permanent disability for loss of use or function of her left forearm and 1 percent (1.5 degrees) scheduled permanent disability for loss of use or function of her right forearm, as granted by an Order on Reconsideration, to zero; (2) upheld the self-insured employer's denial of her current bilateral wrist/forearm condition; and (3) upheld the employer's denial of her current psychological/gastrointestinal condition. On review, the issues are extent of scheduled permanent disability and compensability.

We adopt and affirm the Referee's order with the following supplementation.

Bilateral Wrist/Forearm Claim

The employer accepted a bilateral tendonitis claim for claimant's wrists and forearms. The claim was closed by a February 1993 Notice of Closure that awarded no permanent disability. Claimant subsequently received an award of 2 percent scheduled permanent disability for the left forearm and 1 percent scheduled permanent disability for the right forearm in a September 1993 reconsideration order. The employer denied the compensability of claimant's current bilateral wrist/forearm condition, diagnosed as ganglion-type lesions and tenosynovial herniations, on October 12, 1993.

We agree for the reasons cited in the Referee's order that claimant's current bilateral wrist/forearm condition is not compensable. We also agree with the Referee that claimant has not proved she is entitled to an award of permanent disability for her compensable bilateral wrist condition.

The Referee determined that claimant did not have permanent impairment due to her compensable claim, in part because of reports from Dr. Button, an examining physician (Ex. 44), and a concurrence from Dr. Stanford, the medical arbiter (Ex. 48). These reports were issued, however, after Dr. Stanford's medical arbiter's report of September 15, 1993. (Ex. 43). For this reason, they should not have been considered for purposes of determining permanent impairment. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993).

On review, claimant contends that we should rely on the findings of Dr. Layman, her current treating physician for her bilateral wrist claim, in determining her permanent impairment. She cites Dr. Layman's December 3, 1993 medical report, as well as his April 2, 1993 chart note, in arguing for an award of scheduled permanent disability based on a "chronic condition" and decreased strength. Claimant also contends that Dr. Stanford's medical arbiter's report justifies an award of permanent disability based on reduced range of motion. We disagree with claimant's contentions.

Because Dr. Layman's December 3, 1993 medical report was also issued after the medical arbiter's examination, we do not consider it on review for purposes of rating claimant's permanent impairment. Pacheco-Gonzalez v. SAIF, supra. Although we can consider Dr. Layman's chart note and Dr. Stanford's medical arbiter's report on the issue of extent of disability, we still do not find that claimant is entitled to an award of scheduled permanent disability.

We have previously agreed with the Referee's finding that claimant's current bilateral wrist condition is not related to her compensable wrist/forearm condition. We are unable to determine whether Dr. Layman's or Dr. Stanford's findings are related to claimant's compensable bilateral tendonitis condition or whether they are due to the noncompensable ganglion/tenosynovial condition. Therefore, we cannot conclude that Dr. Layman's finding of a minor reduction in intrinsic muscle strength and Dr. Stanford's range of motion findings are due to the compensable tendonitis claim. Accordingly, we affirm the Referee's conclusion that claimant did not prove entitlement to an award of permanent disability for her compensable bilateral wrist/forearm condition.

Psychological/Abdominal Claim

Claimant experienced psychological difficulties and increased symptoms from a preexisting gastrointestinal condition after she had a confrontation with a co-worker on March 24, 1992. The employer accepted as an occupational disease claim claimant's adjustment disorder with physical complaints and anxious mood. On May 24, 1993, the employer denied claimant's current psychological condition and related gastrointestinal dysfunction. The Referee upheld the denial.

We agree with the Referee's analysis of the compensability of claimant's current psychological condition for the reasons cited in her order. With respect to claimant's current gastrointestinal treatment, the Referee relied on the opinions of Dr. Bennetts, an examining gastroenterologist, and Dr. Haun, a consulting gastroenterologist, in determining that claimant's current abdominal condition was not compensable. Claimant contends that the opinion of her treating gastroenterologist, Dr. Schlippert, is more persuasive.

Dr. Schlippert initially concurred with Dr. Bennetts' opinion that claimant's current gastrointestinal condition is not related to her compensable psychological/abdominal claim of March 24, 1993. (Ex. 29). Dr. Schlippert subsequently issued a report on December 1, 1993, in which he opined that the events of March 24, 1992 were the major contributing cause of claimant's current irritable bowel syndrome. (Ex. 50). However, we do not agree with claimant that Dr. Schlippert's December 1, 1993 report is the most persuasive medical report.

Dr. Schlippert conceded that, while the events of March 24, 1993 had a major impact on claimant's preexisting abdominal condition, "other issues" of which he was not aware played an equally significant role in claimant's symptoms. Dr. Schlippert also stated that it was "relatively unlikely" that the events of one day would be responsible for the prolonged nature of claimant's symptoms. Finally, Dr. Schlippert admitted that a psychological evaluation was necessary in order to assess the causal relationship between claimant's current abdominal condition and the events of March 24, 1993.

Given the equivocal nature of his medical report, we do not find Dr. Schlippert's medical opinion very persuasive. We agree with the Referee that Dr. Bennetts' and Dr. Haun's medical opinions are more persuasive, particularly since they are considerably more definitive on the causation issue than Dr. Schlippert. We, therefore, find that claimant has failed to sustain her burden of proving that her current gastrointestinal condition is compensable.

ORDER

The Referee's order dated January 6, 1994 is affirmed.

August 8, 1994 Cite as 46 Van Natta 1602 (1994)

In the Matter of the Compensation of
TIMOTHY O. LOGSDON, Claimant
WCB Case No. 93-10539
ORDER ON REVIEW (REMANDING)
Bischoff & Strooband, Claimant Attorneys
Betsy Byers (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Mongrain's order that awarded additional temporary disability. On review, the issue is temporary disability. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed an aggravation claim for a compensable low back injury. On September 22, 1992, SAIF denied the claim. Prior to the denial, claimant received interim compensation. After the denial, claimant filed for and received unemployment compensation benefits from September 22, 1992 through

June 7, 1993. On June 7, 1993, SAIF rescinded its denial and agreed to reopen the claim as of April 21, 1992. In calculating claimant's temporary disability benefits, SAIF offset the unemployment benefits claimant had received.

The Referee found that the court's decision in Stone v. Whittier Wood Products, 124 Or App 117 (1993), effectively invalidated the Department's rules for establishing loss of earning power pursuant to ORS 656.212 and necessarily overruled its previous decision in Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987). As a result, the Referee determined that claimant was entitled to temporary total disability benefits during the period in which he had received unemployment benefits, without any offset of those unemployment benefits. In addition, although acknowledging that he could not require claimant to do so, the Referee suggested that claimant reimburse the Department of Employment for the unemployment benefits he had received.

We do not agree that Stone overruled Wells. Whereas Wells addressed the effect of receipt of unemployment benefits on temporary disability compensation, Stone reversed the court's prior holding that, in calculating temporary partial disability (TPD) compensation, "earning power" was defined in terms of a worker's at-injury wage. Because those cases deal with different aspects of the calculation of TPD, they are not mutually exclusive.

In Wells, the court reasoned that "[b]y representing that he is able to work by seeking unemployment benefits, [the] claimant has demonstrated that his disability is no longer total." 86 Or App 742. The court noted that ORS 656.212 provided for TPD and former OAR 436-60-030(1) established procedures for receipt of post-injury wages in the context of TPD. The court affirmed the Board's decision that unemployment benefits could be treated as post-injury wage earnings and could be offset against TPD. In doing so, the court held that "[w]hen a worker is receiving unemployment benefits by representing an ability to work, those benefits may be treated as receipt of post-injury wages." Wells, supra at 86 Or App 743. Furthermore, the court found that an offset of unemployment benefits against TPD was consistent with the legislature's policy, as set forth in ORS 656.012(2)(a), to provide "fair, adequate and reasonable income benefits to injured workers and their dependents[.]" Id. at 86 Or App 741-742.

In Stone, supra, the court concluded that TPD must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. In doing so, the court determined that former OAR 436-60-030(2) was inconsistent with ORS 656.212, in that the rule restricts TPD to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work as required by the statute).

In reaching its conclusion, the Stone court reasoned that an injured worker's post-injury wage is evidence that, depending on the circumstances, may be of great, little, or no importance in determining whether the worker has a diminished "earning power at any kind of work" under ORS 656.212. Specifically, the Stone court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

The court's holding in Stone is not inconsistent with its holding in Wells. Stone sets forth the manner in which to calculate a worker's TPD rate and concludes that post-injury wages do not, in and of themselves, establish whether a worker has a diminished "earning power at any kind of work" pursuant to ORS 656.212. Wells holds that the representations made by a worker in obtaining unemployment compensation take the worker out of the realm of total disability and that unemployment benefits may be treated as receipt of post-injury wages and offset against TPD. Thus, the TPD calculated under the court's guidance in Stone is subject to an offset of unemployment benefits pursuant to Wells. In other words, unemployment benefits, like post-injury wages, may be of great, little, or no importance in determining whether a worker has diminished earning power under ORS 656.212 and Stone.

Applying this reasoning to the present case, claimant was entitled to TPD (not TTD) during the period claimant received unemployment benefits. Wells, supra. However, the record contains no evidence regarding claimant's "earning power at any kind of work," which is necessary to determine claimant's correct rate of TPD. Stone, supra. In light of such circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's temporary partial disability caused a proportionate loss of earning power at any kind of work.

Because of the perceived conflict between Wells and Stone, the parties did not have an opportunity to present evidence or argument on the crucial issue of the proper calculation of claimant's TPD. Moreover, the case was litigated prior to the Director's adoption of temporary rules concerning the calculation of TPD benefits in response to the Stone decision. In light of such circumstances, we find that there is a compelling reason to remand for the submission of additional evidence solely concerning claimant's loss of earning power at any kind of work. See ORS 656.295(5); Lori A. Auterson, 46 Van Natta 262 (1994); Troy Shoopman, 46 Van Natta 21 (1994). At this "remand" proceeding, the parties are also requested to address the effect, if any, the Director's temporary amendments to OAR 436-60-003 and 436-60-030 have on this issue. See WCD Admin Order 94-050.

Accordingly, we vacate the Referee's order dated December 17, 1993. This matter is remanded to Referee Mongrain for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the Referee determines will achieve substantial justice, although we would recommend that evidence concerning claimant's employment history (including past/current wages) be presented. See Shoopman, supra, 46 Van Natta at 22 n.2; see also WCD Admin. Order 94-050. Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated December 17, 1993 is vacated. This matter is remanded to Referee Mongrain for further proceedings consistent with this order.

In the Matter of the Compensation of
ELVA M. McBRIDE, Claimant
WCB Case No. 93-07257
ORDER ON REVIEW
Bryant, Emerson, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee McCullough's order that set aside its denial of claimant's current medical treatment for her low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The employer has moved to strike claimant's respondent's brief, which was due on or before May 2, 1994, on the grounds that the brief was untimely filed. The employer relies on the fact that the envelope containing the respondent's brief was postmarked May 3, 1994, and the postmark on the envelope came from a meter assigned to the law offices of claimant's attorney.

OAR 438-05-046(1)(c) provides that briefs are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." In this case, the certificate of service attached to the brief indicates that it was deposited in the mail on May 2, 1994. Thus, under the applicable administrative rule, claimant's respondent's brief was timely filed. See Lucy E. Buckallew, 46 Van Natta 115 (1994); Duane R. Paxton, 44 Van Natta 375, 376 (1992). Accordingly, the motion to strike is denied.

Compensability

The Referee concluded that claimant's low back condition continued to be compensable. We agree that claimant's low back condition is compensable, but do so based on the following reasons.

On June 10, 1992, claimant compensably injured her neck and low back in a motor vehicle accident. On November 21, 1992 claimant was involved in an off-the-job motor vehicle accident. Prior to the November 1992 accident, claimant was still having major pain with her lower back. (Tr. 17). After the November 1992 accident, claimant continued to experience low back symptoms. (Tr. 20).

In Lucky L. Gay, 46 Van Natta 1252 (1994), the claimant had an intervening, noncompensable motor vehicle accident. We relied on Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994), and Roseburg Forest Products v. Ferguson, 117 Or App 601, rev den 316 Or 528 (1993), and reasoned that the car accident intervened to cause a need for treatment for the claimant's compensable condition resulting from the previously accepted claim. The claimant sought no compensation for a new injury or condition. We decided that the issue was whether the claimant's medical treatment was materially related to the compensable condition.

Likewise, claimant in this case does not seek compensation for a new injury or condition. Therefore, we must decide whether claimant's medical treatment is materially related to her compensable low back injury.

Dr. Holmboe, an orthopedic surgeon, and Dr. Mendius, a neurologist, examined claimant in January 1993 and concluded that claimant's condition was "probably 30 percent due to the first accident at this point and 70 percent due to the second accident, as far as her cervical spine and lumbosacral spine patterns are concerned." (Ex. 9). In a "check-the-box" letter, Dr. Belza, claimant's treating physician, concurred with Drs. Holmboe and Mendius that claimant's injuries from the November 1992 accident were superimposed on the lumbar strain she sustained in the June 1992 accident. (Ex. 9).

In Lucky L. Gay, supra, an intervening noncompensable car accident had caused a need for treatment for the claimant's compensable condition. Nevertheless, since the claimant's compensable injury remained a material contributing cause of his need for medical treatment, we agreed with the claimant that his medical treatment was compensable. Here, we conclude that the medical evidence establishes that claimant's medical treatment is materially related to her compensable low back condition. Thus, claimant has established the compensability of medical services related to her low back following the November 1992 motor vehicle accident.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 27, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
BILLY E. STATEN, Claimant
WCB Case No. 93-05385
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Priscilla M. Taylor, Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the insurer's denial of his cervical condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation.

Claimant began to experience left arm discomfort at work in April of 1992. His treating physician, Dr. Sproat, M.D., diagnosed claimant's condition as epicondylitis (i.e., tennis elbow) (Ex. 2), resulting from an industrial injury. (Ex. 4).

Claimant subsequently filed a Workers' Compensation claim. The insurer accepted his claim as left elbow lateral epicondylitis. The claim was closed by a Notice of Closure on October 19, 1992; no permanent disability was awarded. (Ex. 11).

Claimant returned to Dr. Sproat on December 15, 1992, complaining of a flare-up of his elbow condition. (Ex. 9). Claimant had a "spontaneous recurrence" of severe elbow pain on March 25, 1993, and was examined by Dr. Karmy, M.D. (Ex. 13). Dr. Karmy opined that claimant's left arm condition seemed more like recurrent radiculopathy than lateral epicondylitis. (Ex. 13). Claimant was ultimately referred to Dr. Johnson, M.D., who noted that claimant was experiencing weakness of the left triceps muscle with a numbing, irritated sensation over the lateral aspect of his left elbow. (Ex. 18). Dr. Johnson attributed these conditions to a "very clear C7 radiculopathy." (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, claimant's reply brief was rejected as untimely. See OAR 438-05-046(1)(c). Consequently, we have not considered claimant's reply brief in our deliberations.

Claimant argues that his C6-7 condition is the result of his work activities in April 1992. The insurer contends that claimant did not prove compensability inasmuch as his C6-7 condition presents a complex medical question and there is no expert medical opinion that establishes a causal connection between claimant's work exposure and his current C6-7 condition. We agree that claimant has not demonstrated that his April 1992 compensable injury is a material cause of his C6-7 condition. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991).

Given the nature of claimant's injury, the alternative diagnoses, and the intervening ten months between that injury and the diagnosis of a C6-7 condition, we find that the medical causation question is medically complex, requiring expert medical opinion to resolve. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

After a May 11, 1993 conversation with counsel for the insurer, Dr. Johnson summarized his opinion regarding causation of claimant's cervical condition:

> "I really don't have enough information or have the benefit of a prior exam of 1992 to make a competent statement with regard to causation. . . . I can say that he does have elements of tennis elbow, but certainly a great majority of complaints are coming from his cervical radicular pain at this time." (Ex. 24).

However, in an August 2, 1993 letter from claimant's counsel, Dr. Johnson concurred with a statement that claimant's radiculopathy of C7 was caused by claimant's work-related activity with the employer (Ponderosa Moulding). (Ex. 25).

The only other medical opinion regarding causation of claimant's cervical condition is provided by Drs. Reimer (neurologist) and Logan (orthopedic surgeon), who examined claimant on behalf of the insurer. (Ex. 23). Drs. Reimer and Logan opined that they were unable to document any injury that might have involved claimant's neck in the spring of 1992, while claimant was working for Ponderosa Moulding. (Ex. 23-5). Being unconvinced that claimant was actually suffering from a C6-7 radiculopathy, Drs. Reimer and Logan concluded: "we are unable to identify, within a reasonable degree of medical probability, the material or major contributing cause of [claimant]'s 'current C6-7 radiculopathy.'" (Ex. 23-5). Dr. Sproat concurred with this medical opinion (Ex. 24A), but Dr. Johnson did not. (Ex. 24B).

Based upon the medical evidence, we are unable to conclude that claimant's work exposure in April of 1992 was a material cause of claimant's C6-7 condition. Specifically, the only medical opinion which supports such a causal connection is rendered by claimant's subsequent physician, Dr. Johnson. Although we generally defer to the opinion of a treating physician, we do not do so where there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, we find persuasive reasons not to defer to Dr. Johnson's opinion. Namely, Dr. Johnson's opinion is inconsistent with his previous statement that he was not "competent" to render an opinion regarding causation because he had not examined claimant in April of 1992. (Ex. 24). See Moe v. Ceiling Systems, 44 Or App 429 (1980).

We agree with the Referee that the medical opinions of Drs. Reimer and Logan are complete and well reasoned. Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, we find that claimant has failed to prove that his work activities in April of 1988 were a material cause of his current cervical condition. See ORS 656.005(7)(a).

ORDER

The Referee's order dated October 29, 1993 is affirmed.

August 8, 1994 Cite as 46 Van Natta 1607 (1994)

In the Matter of the Compensation of
CAROLE A. VANLANEN, Claimant
WCB Case No. 91-13600
ORDER ON REMAND
Galton, Scott & Colett, Claimant Attorneys
Julie K. Bolt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. VanLanen 120 Or App 613 (1993), on recon 127 Or App 346 (1994). The court has reversed our prior order, Carole A. VanLanen, 44 Van Natta 1614 (1992), which had affirmed the Referee's order directing the SAIF Corporation to pay temporary and permanent disability compensation awarded in a Determination Order, pending SAIF's appeal of a prior referee's order on compensability. Concluding that, under Diamond Fruit Growers v. Goss, 120 Or App 390 (1993), ORS 656.313 stays payment of compensation pursuant to a Determination Order pending appeal of a referee's compensability order, the court has reversed and remanded for reconsideration.

In light of the court's holding, we reverse the Referee's order which directed SAIF to pay temporary and permanent disability awarded by the August 15, 1991 Determination Order pending review of the prior referee's compensability order. We also reverse the Referee's award of a penalty and attorney fee for SAIF's allegedly unreasonable failure to timely pay compensation awarded by the Determination Order.

ORDER

The Referee's order dated January 8, 1992 is reversed.

In the Matter of the Compensation of
KERMENT C. VERNER, Deceased, Claimant
WCB Case No. 93-10270
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Employer Defense Counsel, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Spangler's order that set aside its denial of a claim for death benefits filed by the deceased claimant's surviving spouse. Arguing that the Referee erred in denying its requests for a continuance of the hearing, the insurer seeks remand for introduction of additional medical evidence concerning the causation issue. On review, the issues are continuance, remand and compensability.

We adopt and affirm the Referee's order with the following supplementation.

The insurer contends that the Referee erred in denying its request for a continuance of the hearing to allow it an opportunity to respond to the medical causation theory presented by Dr. Hamilton, a forensic pathologist. The insurer acknowledges it was technically permissible for claimant to introduce that theory for the first time at hearing through expert testimony, subject only to compliance with the notice provision in OAR 438-07-016. Nevertheless, the insurer argues that claimant's tactic violated the sound policy of the Board to promote full and complete disclosure of the facts and opinions.

The Referee may continue a hearing "[u]pon a showing of due diligence if necessary to afford reasonable opportunity * * * for any party to respond to an issue raised for the first time at a hearing" or for "any reason that would justify postponement of a scheduled hearing under 438-06-081." OAR 438-06-091(3) and (4). The Referee shall not postpone a hearing except upon a finding of extraordinary circumstances beyond the control of the party. OAR 438-06-081. Incomplete case preparation is not grounds for postponement unless the Referee finds that completion of the record could not be accomplished with due diligence. OAR 438-06-081(4).

The language in OAR 438-06-091 is permissive and the authority to continue a hearing is within the Referee's discretion. Nina J. Butler, 46 Van Natta 523 (1994). The Referee found that claimant's beneficiary timely notified the insurer of the expert witness in compliance with OAR 438-07-016. (Tr. 8). Moreover, the Referee found that the insurer had adequate notice of the issues in the case and was not unfairly prejudiced or surprised. (Tr. 7-9).

We disagree with the insurer's assertion that claimant introduced the theory of medical causation for the first time at the hearing. The insurer was notified of claimant's beneficiary's claim on July 7, 1993. In the notification letter, claimant's beneficiary's attorney stated:

> "It appears from the reports that you have sent to me that [claimant] died after ascending 65 feet of stairway, following exposure to extreme heat in the dryer facility earlier in the morning. Furthermore, it appears that the employer was well aware of [claimant's] symptoms of heat exhaustion or exposure. He apparently was allowed to work, unsupervised or without assistance, following employer notice of his health problems." (Ex. 2B; emphasis added).

At the November 23, 1993 hearing, Dr. Hamilton testified that the cause of claimant's death was "due to heat, nausea, vomiting, odors, which led to a cardiovascular accident by -- possibly by hyponatremia and certainly hypokalemia, with cardiac collapse and death." (Tr. 97). Dr. Hamilton testified that the cause of claimant's death could be classified as electrolyte imbalance or heat stroke. (Tr. 101). We conclude that, although the insurer did not know precisely what Dr. Hamilton's testimony would be until the day of the hearing, it had adequate notice of claimant's beneficiary's theory of the case since July 1993 (some four months prior to the hearing).

We conclude that the insurer did not make a showing of due diligence to justify a continuance. See OAR 438-06-091(3). Furthermore, there were no extraordinary circumstances beyond the insurer's control to justify a continuance. See OAR 438-06-081; 438-06-091(4); Georgia-Pacific Corp. v. Kight, 126 Or App 244 (1994). Consequently, we conclude that the Referee did not abuse his discretion in denying the insurer's request for a continuance to allow it an opportunity to respond to Dr. Hamilton's testimony.

The insurer also argues that the Referee erred in denying its request to leave the record open for Dr. Bassett's deposition. Dr. Bassett signed claimant's death certificate on April 3, 1993, and he prepared a medical examiner report on April 12, 1993. (Exs. 2 & 2A). Neither party was aware of Dr. Bassett's April 12, 1993 report until approximately a week before the November 23, 1993 hearing. (Tr. 20-22). The insurer filed the report with the Hearings Division on November 16, 1993, and claimant's beneficiary filed the report on November 18, 1993.

At the hearing, the insurer asked the Referee to leave the record open so that it could cross-examine Dr. Bassett about the April 12, 1993 report. Claimant's beneficiary offered to withdraw the exhibit rather than postpone the hearing. (Tr. 23). The Referee denied the insurer's motion on the grounds that it had submitted the April 12, 1993 report and had suffered no surprise or prejudice.

OAR 438-06-091(2) requires a showing of due diligence if it is necessary to continue a hearing for the opportunity to cross-examine on documentary medical evidence. That rule has no application here because the insurer submitted the report.

Alternatively, even if we applied the rule, the insurer has not made a showing of due diligence to justify a continuance. Because Dr. Bassett signed the death certificate, the insurer has been aware of his involvement at least since August 18, 1993, when it referred to the death certificate in its denial letter. (Ex. 4). Although neither party was aware of Dr. Bassett's April 12, 1993 report until shortly before the hearing, we conclude that the insurer had sufficient notice and opportunity of Dr. Bassett's involvement to obtain his deposition before the hearing. We conclude that the insurer has not shown due diligence or extraordinary circumstances to justify a continuance. See 438-06-081; 438-06-091. The Referee did not abuse his discretion in denying the insurer's request to leave the record open for Dr. Bassett's deposition.

Finally, the insurer contends that we should remand the case to the Referee for further evidence taking. We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed or heard by the referee" so as to justify remand. See ORS 656.295(5). To merit remand, the moving party must establish, inter alia, that the evidence was not obtainable with due diligence at the time of hearing and that it was reasonably likely to affect the outcome of the case. Compton v. Weyerhaueser Co., 301 Or 641 (1986).

We are not persuaded that a compelling reason exists to remand for additional evidence taking. For the reasons previously discussed, we find that the evidence was obtainable with due diligence and therefore remand is not merited.

Claimant's beneficiary is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's beneficiary's attorney's services on review is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's beneficiary's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 20, 1993, as reconsidered on January 10, 1994, is affirmed. For services on review, claimant's beneficiary's attorney is awarded $1,500, to be paid by the insurer.

In the Matter of the Compensation of
SUSAN R. WALLUCK, Claimant
WCB Case No. 92-16085
ORDER ON REVIEW
Werst, Shields, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Crumme's order that upheld the self-insured employer's (Barrett Business Services) denial of claimant's right ankle injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

Barrett (an employee leasing agency) leased employees (including claimant) to PNNA (a doctor's office).

After completing her work shift for PNNA, claimant strained her right ankle while descending a back exterior stairway on the way to the area where she had parked her car.

The stairway is located in an area of a medical building owned, maintained, and controlled by Legacy Health Care. Neither Barrett nor PNNA exercised control of any area outside of PNNA's medical offices.

Neither Barrett nor PNNA directed claimant to park in any particular location.

Neither Barrett nor PNNA directed claimant to enter or leave the building by the back exterior stairway.

Claimant filed an injury claim with Barrett. Barrett denied the claim, on the basis that claimant's injury did not arise out of and in the course and scope of her employment with Barrett.

Claimant did not file a claim with PNNA.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's ankle strain occurred while going home after work and in an area that Barrett did not control. The Referee held, therefore, that claimant's injury did not arise out of and in the course of her employment.

On review, claimant argues that Barrett and PNNA were joint employers of claimant. We need not resolve that question because, even if claimant was a joint employee, we would continue to find the claim not compensable.

As a general rule, injuries sustained by employees when going to and coming from their regular workplace are not deemed to arise out of and in the course of their employment. SAIF v. Reel, 303 Or 210, 216 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). In Norpac Foods v. Gilmore, 318 Or 363 (1994), the Supreme Court recently elaborated on the "parking lot rule." The Court explained that application of this rule establishes only that the time, place, and circumstances of the injury are sufficiently work-related to satisfy the threshold "in the course of" element, but that the second element of the work-connection inquiry must also be satisfied. Thus, to prove compensability, claimant must also establish that her injury "arose out of" her employment. In other words, claimant must also establish a sufficient causal connection between her employment and the injury to prove compensability.

Claimant argues that the "parking lot rule" exception to the going and coming rule applies here because the record establishes that PNNA had the requisite control of the area of injury (the back exterior stairway), as manifested by its right to require the landlord to repair the leased premises or, alternately, by the presence of an employer-created special hazard, i.e., requiring claimant to park in a particular location. We do not find that either PNNA or Barrett had the requisite control over the area of injury (the back exterior stairway). Therefore, we adopt and affirm the Referee's reasoning and conclusion that claimant's injury did not arise out of and in the course of her employment. In addition, we offer the following comments.

Claimant argues that the facts of the instant case closely parallel those in Montgomery Ward v. Cutter, 64 Or App 759 (1983), because claimant, like the claimant in Cutter, worked for an employer that leased space from a landlord, was instructed to park in an area assigned by the landlord, injured herself after work in an off-premises area over which the employer had some control, was walking in a direct line to her car in the designated parking area, and the employer could require the landlord to repair the area where she was injured.

The record does not support claimant's contention that either Barrett or PNNA exercised control over the stairway where claimant was injured. In Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994), a claimant who worked on the fourth floor of an office building was injured when she rode an elevator to the first floor on her unpaid lunch break, when she attempted to step out of the elevator, but the elevator stopped above the level of the first floor. The employer's lease with its landlord gave the employer a nonexclusive right to use the elevator, and gave the employer the right to require the landlord to repair the elevator. The court found that because the employer had the right to require the landlord to repair the elevator, there was a sufficient connection between the employer and the area where the claimant's injury occurred to satisfy the "in the course of" element of the work-connection test. Id. at 337.

Claimant argues that PNNA's lease with Legacy establishes that Barrett, through its employee leasing agreement with PNNA, had control over the back exterior stairway. Claimant points to Article 27.1 of the agreement as support for her contention. Unlike the lease in Henderson, in the Legacy/PNNA lease, Legacy retained control of all areas other than those areas it leased to tenants. The cited portion of the Legacy/PNNA lease provides only that:

> "27.1: The Lessor [Legacy], for the proper maintenance of said building, the rendering of good service, and the providing of safety, order and cleanliness may make and enforce regulations appropriate for such purposes[.]" (emphasis supplied).

Contrary to claimant's assertion, the lease does not give PNNA the right to require Legacy to repair any non-leased areas such as the stairway where claimant's injury occurred.

Neither does the record support claimant's contention that either Barrett or PNNA directed claimant to park in any particular location, thereby increasing her risk of injury. Legacy restricted parking beneath its medical building to physicians with offices in the building. Office staff employees were prohibited from parking in that location. Legacy did permit non-physician employees to park in either of two other parking lots. Claimant could also park on adjacent public streets. However, neither Legacy, Barrett nor PNNA directed claimant to park in any particular location.

On this record, we do not find that either Barrett or PNNA exercised control over the stairway where claimant was injured, as manifested by either entities' right to require the landlord to repair the stairway or by the presence of an employer-created special hazard. Based on the reasoning expressed above, as well as for the reasons expressed in the Referee's decision, we find that claimant has not established that her injury is compensable under the "parking lot" exception to the going and coming rule.

ORDER

The Referee's order dated July 23, 1993 is affirmed.

In the Matter of the Compensation of
DENNIS D. BENSON, Claimant
WCB Case Nos. 93-11590 & 93-07203
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant request review of those portions of Referee Spangler's order that: (1) upheld the SAIF Corporation's denial (on behalf of Bay Area Yamaha) of claimant's neck and low back "new" injury claim; and (2) upheld SAIF's denial (on behalf of Benson Creek Trucking) of claimant's aggravation claim for a low back condition. On review, the issues are aggravation and compensability.

We adopt and affirm the Referee's order with the following supplementation. On Board review, claimant contends that the Referee's adverse credibility determination should not carry any weight because he based it on the substance of claimant's testimony about collateral matters.

We agree with claimant that some of claimant's testimony, which the Referee found untrustworthy, concerned collateral matters. Specifically, claimant's testimony about his workdays in September 1993 and about the work he allegedly did in 1991 and 1992 for Richard Spring, his landlord, had no discernible relevance to issues of the case. Had the credibility finding been based substantially on that evidence, we would agree with claimant that it should not carry much weight.

However, the credibility determination was not based substantially on that evidence. The other points made by the Referee were well-founded and substantial. Furthermore, his determination was based on claimant's demeanor when testifying.

Finally, in deferring to and adopting the Referee's credibility determination, we are mindful of certain medical reports from treating or consulting physicians which expressly warn that the prognosis for recovery from claimant's compensable condition would be poor, if claimant were permitted to make extensive use of time loss benefits without strong evidence of a new injury. (See Exs. 33 and 35).

ORDER

The Referee's order dated October 8, 1993 is affirmed.

In the Matter of the Compensation of
THOMAS A. HAGERT, Claimant
WCB Case No. 93-03921
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Mongrain's order which upheld the self-insured employer's denial of claimant's polyarthritis condition. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation.

The Referee, in determining that claimant's polyarthritis condition was not compensable, found the opinion of the examining physician, Dr. Rosenbaum, more persuasive than those of claimant's family physician, Dr. Johnson, and a rheumatologist, Dr. MacKinnon. Both Dr. MacKinnon and Dr. Johnson related claimant's polyarthritis condition to his compensable injury, whereas Dr. Rosenbaum did not. Claimant contends that Dr. Rosenbaum's opinion was based on an inaccurate understanding of claimant's injury. Therefore, he argues that the Referee erred in relying on Dr. Rosenbaum's medical opinion. We disagree.

During his examination of claimant, Dr. Rosenbaum recorded a history that claimant was struck on the left side of his body when steel fell from a truck. Dr. Rosenbaum ultimately concluded that such "localized trauma" was not a likely explanation for claimant's arthritic condition and that a systemic illness, such as pneumonia, was a greater contributing cause of the condition. (Ex. 32). Claimant asserts that his injury resulted in more than localized trauma.

Although claimant's accounts of his injury have varied, the medical records indicate that claimant's injury was predominantly left-sided. (Exs. 1, 4, 5, 16-1, 32). Moreover, claimant, himself, testified that his injury was primarily left-sided. (Tr. 17). We, therefore, conclude that Dr. Rosenbaum's history was sufficiently accurate. The Referee could accordingly rely on Dr. Rosenbaum's medical opinion in finding that claimant's condition was not compensable. We also agree for the reasons cited in the Referee's order that Dr. Rosenbaum's is the most persuasive medical opinion.

Claimant also contends that his compensable left wrist, left hip and lumbar sprain injury made his preexisting arthritic condition symptomatic. Thus, he asserts that his medical treatment is compensable under U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). We do not find Burtis controlling in this case.

In Burtis, the medical evidence established that the claimant's cervical strain rendered a preexisting degenerative disc disease symptomatic, resulting in a need for medical treatment. Under those circumstances, claimant's need for treatment was compensable under ORS 656.005(7)(a)(B). 120 Or App at 359.

In this case, however, the medical evidence does not establish that claimant's compensable injury rendered his preexisting condition, variously described as spondylarthropathy (Dr. MacKinnon), psoriatic arthritis (Dr. Rosenbaum), and sacroiliitis (Dr. Johnson), symptomatic. Dr. Rosenbaum opined that a non-work related systemic infection such as pneumonia was the likely explanation for claimant's arthritic symptomatology involving multiple joints. (Ex. 32). Inasmuch as Dr. MacKinnon and Dr. Johnson never addressed the impact of a viral infection on claimant's preexisting arthritic condition, even though Dr. MacKinnon raised the possibility of such an infection, their opinions are not as persuasive as Dr. Rosenbaum's. Thus, the medical evidence fails to establish that claimant's compensable injury rendered the preexisting arthritic condition symptomatic, resulting in a need for medical treatment. Burtis is, therefore, inapposite.

In conclusion, we agree with the Referee that claimant has failed to sustain his burden of proving his compensable injury is the major contributing cause of his need for treatment under ORS 656.005(7)(a)(B). The Referee properly upheld the employer's denial.

ORDER

The Referee's order dated December 20, 1993 is affirmed.

In the Matter of the Compensation of
PAUL M. JORDAN, Claimant
WCB Case Nos. 92-15882 & 92-15881
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Carolyn Ladd (Saif), Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee Mongrain's order that: (1) set aside its denial of claimant's current low back condition claim; and (2) upheld the responsibility portion of Liberty Northwest Insurance Corporation's denial of claimant's "new" injury claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but not his supplemental finding of fact. In addition, we make the following findings.

On September 30, 1992, claimant filed an 801 form with Liberty, contending that he had sustained a new injury in July 1992. Claimant did not file a claim with SAIF.

On October 29, 1992, Dr. Purtzer, claimant's treating neurosurgeon, forwarded a "Notice of Intent to Perform Surgery" to Liberty. On November 2, 1992, Liberty denied the compensability of and disclaimed responsibility for claimant's current low back condition. Liberty suggested that claimant's current condition was related to claimant's 1984 injury with SAIF's insured. Liberty sent a copy of its denial/disclaimer to SAIF.

On November 16, 1992, SAIF issued a "Disclaimer of Responsibility and Denial of Compensability" for claimant's current low back condition. SAIF indicated that Liberty was responsible for claimant's condition and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF's disclaimer was untimely because it was issued more than 30 days after SAIF received a medical report from Dr. Kirkpatrick indicating that claimant's current condition might be related to employment exposure at Liberty's insured. The Referee concluded, therefore, that SAIF was precluded from arguing that Liberty is responsible. See ORS 656.308(2). Alternatively, the Referee concluded that SAIF had failed to establish that claimant sustained a new compensable injury and, therefore, that responsibility for claimant's current low back condition remains with SAIF.

On review, SAIF argues that its disclaimer was not untimely. Alternatively, on the merits, SAIF argues that claimant's work activities in 1992 at Liberty's insured are at least a material contributing cause of claimant's current low back condition.

ORS 656.308(2) provides, in relevant part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. * * * Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, * * * if that notice was given as provided in this subsection." (Emphasis supplied).

Contrary to the Referee, we do not find that SAIF's disclaimer was untimely, thereby precluding SAIF from arguing that Liberty is responsible for this claim. We reason as follows.

Claimant has an accepted 1984 low back injury claim with SAIF. Claimant began working for Liberty's insured in late April 1992. On August 2, 1992, claimant presented to Dr. Kirkpatrick with severe lower back and leg pain beginning in late July 1992. Dr. Kirkpatrick reported that claimant had a new protruded disc at L5-S1, was having additional low back problems, was seeking additional treatment, and was employed by another employer, namely Liberty's insured. (Ex. 35). At hearing, SAIF stipulated that it received Exhibit 35 on August 5, 1992. (Tr. 3).

We do not find that Dr. Kirkpatrick's report constituted a claim that named or joined SAIF. See ORS 656.308(2). Rather, we find that Dr. Kirkpatrick's report primarily suggested that claimant's current condition was related to employment exposure at Liberty's insured. Because Dr. Kirkpatrick's report did not constitute a ORS 656.308(2) "claim," SAIF was not required to issue its disclaimer within 30 days of August 5, 1992.

On November 2, 1992, Liberty issued its responsibility disclaimer, naming SAIF as a potentially responsible insurer. Liberty sent a copy of its denial/disclaimer to SAIF. We find that Liberty's November 1992 disclaimer was SAIF's first notice that it was being "named or joined in the claim." See ORS 656.308(2). Therefore, inasmuch as SAIF issued its responsibility disclaimer on November 16, 1992, within 30 days of being "named in the claim," we conclude that SAIF's disclaimer was not untimely under ORS 656.308(2). Accordingly, SAIF is not precluded from defending this claim on the basis of claimant's subsequent employment exposure at Liberty's insured.

Turning to the merits, the Referee found that claimant's work activities in July 1992 were not a material contributing cause of his low back condition and need for treatment. We agree with and adopt the Referee's ultimate conclusion that SAIF has failed to establish that claimant sustained a new compensable injury. However, we offer the following comment concerning the applicable standard of proof.

Subsequent to the Referee's order, the Supreme Court held that ORS 656.005(7)(a)(B) applies in the responsibility context to determine whether or not a worker sustained a "new compensable injury" under ORS 656.308. SAIF v. Drews, 318 Or 1 (1993). The Supreme Court reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior carrier is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer only if the injury is found to be "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the major contributing cause, responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

As the insurer with the accepted 1984 claim, SAIF has the burden of proof. Accordingly, to establish that claimant sustained a "new" injury after the closure of claimant's 1984 injury claim, SAIF must prove that claimant's work activities following closure of that claim were the major contributing cause of claimant's current low back condition. See SAIF v. Drews, supra.

Here, the evidence establishes that claimant has had a chronic and recurring condition since the 1984 compensable injury at SAIF's insured. SAIF accepted a low back sprain/strain, which ultimately led to surgery in 1986 for protruded L3 and L5 discs, and surgery in 1990 for a protruded L4 disc. The claim was ultimately closed by an April 10, 1991 Determination Order, with a total award of 42 1/2 percent unscheduled permanent disability.

Following his 1984 injury and his 1986 and 1990 surgeries, claimant continued to experience low back pain and radiculopathy. Claimant noticed an increase in his symptoms in July 1992, while working for Liberty's insured. Claimant contends that he is simply experiencing a continuation of his low back symptoms dating back to his original 1984 injury and claim with SAIF.

We adopt and affirm the Referee's reasoning and conclusion that the preponderance of the medical evidence establishes that claimant's work activities in July 1992 contributed only minimally to claimant's current disability and need for treatment. We conclude, therefore, that SAIF has not established that claimant's work activities following closure of that claim were either a material or the major contributing cause of claimant's current low back condition. Accordingly, responsibility for claimant's current low back condition does not shift to Liberty, but remains with SAIF. See Id.

The parties litigated both compensability and responsibility at hearing. Although compensability was not raised on review, it was an issue at hearing. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Consequently, claimant is entitled to an assessed fee for services on review. ORS 656.382(2); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee fee for claimant's counsel's services on review is $750, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 16, 1993, as amended on June 25, 1993, is affirmed. For services on review, claimant's attorney is awarded $750, payable by the SAIF Corporation.

In the Matter of the Compensation of
A. D. ROHRSCHEIB, Claimant
WCB Case No. 93-01362
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Westerband, Hall, and Haynes.

Claimant requests review of Referee Hoguet's order which: (1) found that claimant had not filed a claim for ulnar compression neuropathy, median compression, or carpal/cubital tunnel syndrome; and (2) dismissed claimant's hearing request concerning the self-insured employer's alleged "de facto" denial of these claims. On review, the issues are claim processing and compensability. We reinstate claimant's hearing request and address claimant's claim for his current conditions.

FINDINGS OF FACT

We adopt the Referee's findings of fact, and the parties' stipulations as set out in the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a hyperextension injury to his right elbow in May 1991 while fighting a fire. His claim was accepted for right elbow tendonitis. Claimant had right elbow arthroscopic surgery in December 1991. The claim was closed by Determination Order on May 11, 1992 with an award of 10 percent scheduled permanent disability. An Order on Reconsideration increased the award to a total of 18 percent scheduled permanent disability.

Claimant continued to have right arm symptoms. In October 1992, Dr. Long, consulting physician, examined claimant. He diagnosed "incidental ulnar compression neuropathy at the elbows, symptomatic right but not left, untreated," and "incidental median compression in the palms, symptomatic right but not left, untreated." (Ex. 34-7).

In January 1993, Dr. Puziss, on referral from Dr. Long, examined claimant for right elbow pain. Dr. Puziss diagnosed "probably mildly symptomatic carpal and/or cubital tunnel syndrome secondary to [right elbow strain/contusion]." (Ex. 36-4).

Claimant requested a hearing on March 12, 1993, contending that the insurer had denied, "de facto," right ulnar and median compression neuropathy as indicated in Dr. Long's October 22, 1992 report. At hearing, claimant raised, without objection, an additional issue of a "de facto" denial of carpal and/or cubital tunnel syndrome. The employer argued that neither Dr. Long's nor Dr. Puziss' report constituted a claim because no treatment was required for any of the conditions mentioned in the reports.

The Referee concluded that neither Dr. Long's October 1992 report (Ex. 34) nor Dr. Puziss' January 1993 report (Ex. 36) were claims for compensation. See ORS 656.005(6), (8). Therefore, the Referee dismissed claimant's request for hearing.

We adopt the Referee's conclusions that Dr. Long's report (Ex. 34) does not constitute a claim. We agree with the Referee's reasoning that Dr. Long referred to the ulnar and median compression neuropathy as "incidental," and did not link them to claimant's compensable injury.

On the other hand, we find that Dr. Puziss' January 1993 report (Ex. 36) is a claim for compensation. Consequently, we reverse that portion of the Referee's order which held to the contrary.

A claim is a "written request for compensation from a subject worker or someone on the worker's behalf." ORS 656.005(6). The request does not have to take any particular form. A physician's report requesting medical services for a specified condition in addition to medical treatment being provided for the accepted condition consititutes a claim. Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992).

Here, after his December 1991 arthroscopic surgery, claimant continued to be symptomatic and to seek medical care for right elbow pain caused both by the original injury and carpal/cubital tunnel that became symptomatic because of the original injury. In January 1993, Dr. Puziss believed that if claimant's symptoms worsened, he should have a further arthroscopy. (Ex. 36-4). Furthermore, Dr. Puziss recommended vitamin and mineral supplements, and requested that claimant return for follow-up in 2-3 months.

Thus, claimant sought treatment for the compensable elbow pain and for pain related to the carpal/cubital tunnel. In addition, directly relating the diagnosed carpal/cubital tunnel syndrome to the compensable injury, Dr. Puziss recommended follow-up and possible surgery. Under such circumstances, we conclude that Dr. Puziss' medical report constitutes a claim for compensation. ORS 656.005(6), (8).

Inasmuch as we have found that a claim for compensation had been filed, we address compensability of claimant's claim for right carpal/cubital tunnel syndrome.

Dr. Long concluded that claimant had preexisting lesions at the wrists and elbows prior to his compensable May 1991 injury. (Ex. 34-4). Dr. Puziss stated that the original injury caused claimant's mild carpal/cubital tunnel syndrome to become symptomatic. (Ex. 36-4). Under such circumstances, we find that claimant must establish that the compensable injury is the major contributing cause of his resultant disability and need for treatment. See ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) (if a work injury renders a preexisting asymptomatic condition symptomatic, the current condition is compensable as long as the injury is the major contributing cause of the worker's resultant need for treatment).

In April 1993, Dr. Long reiterated that claimant had asymptomatic median compression and ulnar nerve lesions at the elbows prior to his May 1991 injury. (Ex. 37-1). He further stated that the compensable injury was not the major contributing cause, or a material cause, of the original development of the lesions. However, Dr. Long opined that claimant's May 1991 work injury was the major contributing cause of the development of symptoms of the right median and ulnar nerve lesions. Id.

We find that both doctors' opinions support a direct relationship between claimant's compensable right elbow injury and the development of symptoms of his previously asymptomatic right carpal/cubital tunnel syndrome. Therefore, we conclude that it is more likely than not that claimant's 1991 compensable injury is the major contributing cause of his resultant disability and need for medical treatment for his right carpal/cubital tunnel syndrome. Accordingly, claimant has met his burden of proving compensability of his right carpal/cubital tunnel syndrome. U-Haul of Oregon v. Burtis, supra.

Claimant is entitled to an assessed attorney fee for prevailing on the right carpal/cubital tunnel syndrome issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $2,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs, and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated May 19, 1993 is reversed in part and affirmed in part. Claimant's request for hearing is reinstated. The self-insured employer's "de facto" denial of claimant's right carpal/cubital tunnel syndrome claim is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $2,500, payable by the employer. The remainder of the Referee's order is affirmed.

Board Member Haynes dissenting:

Because the majority's opinion contravenes the long-established legal definition of "claim," I dissent.

ORS 656.005(6) defines a claim, in part, as "a written request for compensation for a subject worker or someone on the worker's behalf, * * *."

Compensation is defined, in part, as "all benefits, including medical services, provided for a compensable injury to a subject worker * * *." ORS 656.005(8). The Court of Appeals has concluded that, under the two statutes, a physician's report requesting medical treatment for a specified condition constitutes a claim. Safeway Stores, Inc, v. Smith, 117 Or App 224 (1992). (Emphasis added).

In Smith, the court agreed with the Board conclusion that a physician's report stating that claimant had "right shoulder, neck and arm pain, as well as shooting pain down the left arm, and prescrib[ing] physical therapy and medication" constituted a claim. Smith, supra at 228. (Emphasis in original).

Here, Dr. Puziss diagnosed:

> "1) History contusion/strain right elbow with subsequent development of traumatic arthritis.
>
> "2) Status post right elbow arthroscopic synovectomy.
>
> "3) Probably mildly symptomatic carpal and/or cubital tunnel syndrome secondary to #1." (Ex. 36-4).

Dr. Puziss arrived at the following conclusions after examining claimant and reviewing claimant's medical record:

> "1) that claimant had a significant strain injury to his right elbow, and had been symptomatic ever since;
>
> "2) that the joint has been traumatized, causing arthritis and requiring arthroscopic surgery which did not cure claimant, but was probably palliative; and
>
> "3) that claimant has symptomatic mild carpal and cubital tunnel syndrome caused by the original injury, that does not require surgery at this time." Id.

In reaching its conclusion that Exhibit 36 constitutes a claim for medical services for carpal/cubital tunnel, the majority misinterprets Dr. Puziss' report. In the first place, claimant was referred to Dr. Puziss for his "chief complaint of right elbow pain," not for carpal/cubital tunnel. (Ex. 36-1).

Secondly, the "possible surgery" recommended by Dr. Puziss is arthroscopic surgery for claimant's elbow, not surgery for carpal/cubital tunnel. (Ex. 36-4). Dr. Puziss discussed future deterioration of claimant's elbow and the need for future arthroscopy if the mechanical symptoms of the elbow (including catching and locking, or roughening of the joint from arthritis) became worse. Id. Furthermore, Dr. Puziss stated that claimant probably remained medically stationary.

Finally, it is very difficult, if not impossible, to discern from the report the reason Dr. Puziss recommended vitamin and mineral supplements. However, considering the fact that the recommendation followed two paragraphs' discussion of claimant's elbow condition, it would require a stretch of the imagination to conclude that the vitamins were recommended for carpal/cubital tunnel.

In conclusion, after Dr. Puziss' initial comment stating that claimant's preexisting carpal/cubital tunnel condition became symptomatic after the compensable elbow injury, Dr. Puziss' report contains no further discussion of carpal/cubital tunnel. Accordingly, Dr. Puziss' report cannot reasonably be interpreted to constitute a claim for medical services for carpal/cubital tunnel which the insurer denied "de facto."

In the Matter of the Compensation of
WONDER WINDOM-HALL, Claimant
WCB Case No. 90-06799
ORDER ON REVIEW (REMANDING)
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Davis' order that: (1) upheld the self-insured employer's denials of inner ear conditions, brain condition and psychological condition; and (2) declined to award a penalty and related attorney fee for an allegedly unreasonable denial. Claimant also moves for remand for admission of additional evidence. On review, the issues are compensability, penalties, attorney fees, and remand. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In 1989, claimant sought treatment for headaches, dizziness and nausea. The employer accepted the claim. Claimant subsequently was diagnosed with various vestibular conditions, including perilymph fistulas, and toxic encephalopathy. Claimant asserts that such conditions were caused by industrial toxic exposure and, therefore, are compensable. Claimant also contends that she developed dysthymia as a result of her inner ear disorders and toxic encephalopathy.

The Referee found that claimant failed to prove the compensability of any of her conditions. Along with challenging such findings by the Referee, claimant, on review, moves for remand for admission of additional evidence. Specifically, claimant alleges that, following the hearing, she underwent surgery on her left ear during which a perilymph fistula was revealed and repaired. Claimant argues that a compelling reason exists for remanding because such evidence concerns claimant's disability, was not obtainable at hearing, and is reasonably likely to affect the outcome of the case because it increases the reliability of the medical evidence that supported compensability. We agree.

Under ORS 656.295(5), we may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the

case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

We conclude that claimant has established a compelling reason for remand. The evidentiary record is voluminous, due in major part to the difficult and complex medical questions involved. The record reflects strong differences of medical opinion about the cause, and, indeed, the nature of claimant's physical disorders.

At hearing, the employer challenged the diagnosis of vestibular disorders, including perilymph fistula, asserting, in part, that claimant's symptoms were due to a conversion disorder. This defense was supported by medical evidence indicating that claimant's symptoms related to a psychological condition rather than toxic exposure. (Exs. 38, 43A, 45, 46, 48, 49, 64). The Referee's order indicates that he was persuaded by this defense to some extent since he stated that the question of whether claimant had vestibular disorders was "vexed" and noted the evidence of a conversion or somatization disorder. In short, the results of the surgery that claimant underwent post-hearing are likely to shed considerable light on the question of the nature of claimant's disorder. How that question is decided is likely to be relevant and material to the ultimate question of compensability. The new evidence will certainly bear directly on the persuasiveness of several of the medical opinions. Clearly, the evidence derived from this "post-hearing" surgery could not have been obtained with due diligence, and thus, remand is appropriate. See Palmer v. Plaid Pantry #54, 76 Or App 405 (1985); Duane R. Paxton, 42 Van Natta 2562 (1990).

Having found that claimant proved a compelling reason, we grant her motion to remand for admission of additional evidence regarding claimant's post-hearing surgery. In addition, the Referee shall allow the employer an opportunity to cross-examine or rebut the proferred evidence. The submission of this additional evidence shall be made in any manner that the Referee determines will achieve substantial justice.

On Board review, claimant also contends that the employer's partial denial was actually a "back-up" denial under ORS 656.262, and thus, the employer has the burden to disprove compensability by clear and convincing evidence. Whether or not the partial denial was a "back-up" denial which shifted the burden of proof to the employer is also a question we refer to the Referee for decision upon remand.

Accordingly, the Referee's order dated July 27, 1993 is vacated. This matter is remanded to Referee Davis for further proceedings consistent with this order. Following these further proceedings, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID L. JOHNSON, Claimant
WCB Case No. 92-13365
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Mongrain's order which upheld the insurer's partial denial of claimant's injury claim for bilateral carpal tunnel syndrome, thoracic outlet syndrome, degenerative disc disease at C5-6 and C6-7, stress fracture at C-6, and a recommended surgical procedure. In his brief, claimant argues that the conditions had previously been accepted. On review, the issues are claims processing and compensability.

We adopt and affirm the Referee's order with the following supplementation.

Claimant sustained an injury on January 24, 1992 when a 10-pound choker hook hit his hard hat. On February 11, 1992, the insurer denied a "possible cervical fracture and moderate cervical strain/sprain." (Ex. 18). On February 21, 1992, the insurer rescinded its denial of "possible cervical fracture and moderate cervical strain/sprain," and stated that it was accepting the claim. (Ex. 21). On March 4, 1992, the insurer sent claimant a Notice of Claim Acceptance which specifically accepted "cervical strain." (Ex. 25). On October 29, 1992, the insurer issued a partial denial of bilateral carpal tunnel syndrome, thoracic outlet syndrome, degenerative disc disease at C5-6 and C6-7, stress fracture at C-6, and a recommended surgical procedure. (Ex 75).

Claimant contends that the language of the February 21, 1992 rescission of the denial effected an acceptance of claimant's cervical fracture and all associated symptoms (and subsequently diagnosed conditions) for which claimant was treating at the time of the injury, or shortly thereafter. In other words, claimant argues that the October 29, 1992 denial was a "back-up" denial of previously accepted conditions. See ORS 656.262(6). We do not agree.

At hearing, when asked to clarify the issues, claimant's attorney stated that claimant's injury resulted in the need for medical treatment for the denied conditions, and claimant was seeking to set aside the October 1992 denial of those conditions. (Tr. 7, 8). For the first time on appeal, claimant argues that the conditions had been previously accepted. Therefore, we decline to address this "back-up" denial issue. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

We conclude that the Referee correctly framed the issue at hearing as whether the denied conditions were directly caused by claimant's January 1992 injury (material contributing cause) or whether the conditions are a consequence of the compensable injury (major contributing cause). See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We further agree with the Referee that claimant has failed to prove that the conditions are related in a material or major way to the January 1992 compensable injury.

ORDER

The Referee's order dated October 27, 1993 is affirmed.

August 10, 1994 Cite as 46 Van Natta 1621 (1994)

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
ORDER OF ABATEMENT
Craine & Love, Claimant Attorneys
Pamela A. Schultz, Defense Attorney

On July 29, 1994, we affirmed a Referee's order which awarded claimant 34 percent (51 degrees) scheduled permanent disability for loss of use or function of the right forearm. In reaching this conclusion, we declined to rely on impairment findings from Dr. Johnson because the record did not establish that Dr. Johnson was licensed to practice medicine in the state of Oregon. See ORS 656.245(3)(b)(B); 656.005(12)(b)(A).

Claimant requests reconsideration based on the following grounds. First, Dr. Johnson's status an "attending physician" authorized to render impairment findings was not challenged at hearing. But see Gary C. Fischer, 46 Van Natta 221 (1994) (Regardless of whether evidence specifically challenged on the basis that it did not pertain to the claimant's condition at the time of a reconsideration order, the Board is mandated to perform such an evaluation in weighing the medical evidence to determine the extent of the claimant's permanent disability). Secondly, submitting a "post-hearing" report from Dr. Johnson which indicates that he was also licensed to practice medicine in Oregon, claimant seeks remand for further consideration of this issue.

In order to further consider this matter, we withdraw our July 29, 1994 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN W. ANDREWS, Claimant
WCB Case Nos. 93-08329 & 93-05174
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys
Jim B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Westerband and Haynes.

The SAIF Corporation requests review of those portions of Referee Schultz's order that: (1) set aside SAIF's denial of claimant's injury claim for lumbar strain and left leg bruises; and (2) upheld Sedgwick James and Company's denials of those conditions. On review, the issues are compensability and, alternatively, responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, under the factors enunciated in Jordan v. Western Electric, 1 Or App 441 (1970), claimant established that his current injuries arose out of and in the course of his employment. On review, SAIF argues that, because claimant was injured while violating the employer's express prohibition against lifting heavy objects, claimant's injuries occurred outside the course of his employment. We agree.

Claimant has had a long history of back problems related to his employment with Sedgwick James' insured. In May 1992, claimant began working for SAIF's insured (the employer), a plumbing company, purchasing and delivering parts and acting as a plumbing assistant. Claimant's work required that he lift objects, such as water heaters and pipe machines, which weigh at least 100 pounds.

In October 1992, claimant told the employer that he had a history of back problems. At that time, the employer verbally restricted claimant from lifting. (Tr. 53). The employer communicated this restriction to its main supplier, saying that, when claimant arrived to pick up supplies, the supplier, and not claimant, would have to load the supplies. (Tr. 54-55).

Following the employer's verbal restriction, at least one situation arose in which claimant assisted another person to move a heavy water heater because no one else was available to help. (See Tr. 26-27). However, claimant does not contend, and there is no evidence that, the employer knew about or acquiesced in this particular work rule violation.

On March 24, 1993, while delivering some plumbing supplies, claimant helped a non-coworker move a 200-pound expresso machine, because no one else was available to help. While helping the non-coworker, claimant tripped and fell, sustaining his current back and left leg injuries.

SAIF argues that claimant's violation of the employer's no-lifting policy constituted misconduct sufficient to take claimant's injury out of the course and scope of his employment. Before we address that argument, we must determine whether a violation actually occurred. We conclude that it did.

Claimant does not specifically address this issue. In his brief, he asserts that, "even after the verbal restrictions [were imposed], situations still arose in claimant's job where he was expected to lift heavy [objects]. (Tr. 27)." (Claimant's Respondent's Brief at 6). Based on that assertion, it appears that claimant's argument would be that the employer's no-lifting restriction only prohibited him from lifting when assistance was available. Therefore, claimant must be essentially contending that, because he injured himself lifting an expresso machine when no one else was available to help, he did not violate the employer's no-lifting restriction.

We reject that argument. Claimant mischaracterizes what happened after the employer established the verbal no-lifting restriction. In point of fact, there is no evidence that the employer expected claimant to do any heavy lifting following the imposition of the no-lifting restriction. Indeed, the record reveals just the opposite. The employer testified:

"Q. And you knew occasionally he might even be lifting pipe machines, right?

"A. Not with my approval he wouldn't.

"Q. How much does a pipe machine weigh?

"A. In the neighborhood of 100 pounds.

"Q. So whenever he had a pipe machine, you'd expect him to get help? Is that the idea?

"A. Exactly.

"Q. From people at the site?

"A. Exactly.

"Q. And you knew he would need to do that occasionally, right?

"A. Yes, sir.

"Q. In fact, you expected him to get help after you found out about his back injuries?

"A. Yes." (Tr. 59-60).

Furthermore, the employer told its main supplier that claimant was not to lift any heavy objects when he came to retrieve supplies. (See Tr. 54-55). Read as a whole, the record establishes that, when heavy equipment had to be moved, claimant was to ask other people to move it; he was not to move the equipment himself. It follows that, by helping to move the expresso machine, claimant violated the employer's no-lifting restriction. We must next determine whether that misconduct took claimant's injury out of the course and scope of his employment.

The test for determining whether an employee's misconduct involved activities that are outside the course and scope of employment is stated by Professor Larson:

> "When misconduct involves a prohibited overstepping of the boundaries defining the ultimate work to be done by the claimant, the prohibited act is outside the course of employment. But when misconduct involves a violation of regulations or prohibitions relating to the method of accomplishing that ultimate work, the act remains within the course of employment." 1A Larson, Workmen's Compensation Law 6-8, § 31.00 (1985) (emphasis in original).

Applying this rule, the Court of Appeals and this Board have held that a claimant's violation of a specific directive not to perform certain work constitutes overstepping the boundaries defining the claimant's ultimate work. Davis v. R & R Truck Brokers, 112 Or App 485 (1992) (violation of directive to return employer's truck to worksite on day of injury); Michael Thornton, 45 Van Natta 743 (1993) (violation of directive not to work on day of injury).

Here, the employer specifically directed claimant not to lift heavy objects, because of claimant's history of back problems. Claimant ignored this directive when he helped a non-coworker move the expresso machine. By doing so, claimant overstepped the boundaries of the work he was to do for the employer, and therefore was outside the course and scope of his employment when he was injured. See Davis v. R & R Truck Brokers, supra; Michael Thornton, supra.

We find this case to be distinguishable from cases involving violations of work rules governing a worker's method of accomplishing his or her ultimate work. In David Bottom, 46 Van Natta 1485 (1994), the claimant was injured when a box fell on him while he was unloading freight. At the time, the claimant was intoxicated, although his injury was not related to his intoxication. The employer had a policy specifically prohibiting the use of drugs and alcohol at work. Reasoning that the employer's

policy related to its desire that its employees work unencumbered by drugs or alcohol, and not to the claimant's ultimate freight unloading responsibilities, we concluded that the claimant's violation of the drug and alcohol policy was a violation of a rule concerning the method of execution of his ultimate work duties. Id. at 1487. Therefore, we concluded that claimant's injury occurred within the course and scope of his employment.

In Patterson v. SAIF, 64 Or App 652 (1983), the claimant was a security guard for the employer, Oregon Health Sciences University. The employer had a rule prohibiting the transport of unwanted persons beyond the edge of the employer's premises. Although the claimant knew of this rule, he transported an unruly patient to a destination beyond the edge of the employer's premises, at which point he was injured. The court concluded that the claimant's disregard of the employer's work rule did not involve a prohibited overstepping of the boundaries defining his ultimate job responsibilities, i.e., the transportation of unwanted persons off the premises. Id. at 656. Instead, the court concluded that the employer's rule concerned the sphere of execution of the claimant's employment responsibilities. Id. at 656. Reasoning that the claimant's misconduct was a violation of the designated method of execution of his ultimate work, the court concluded that claimant's injury was sufficiently work-related to be compensable. Id.

In both Bottom and Patterson, the claimants' misconduct involved violation of rules concerning how they were to perform their ultimate work responsibilities. In Bottom, the claimant violated a work rule designed to ensure that he performed his ultimate work duties in a sober state; in Patterson, the claimant's misconduct involved a rule that merely limited the sphere within which he was to perform his ultimate work duties.

Here, in contrast, the employer's prohibition against heavy lifting actually established the boundaries of claimant's ultimate work duties. That is, it contemplated that claimant would perform his usual duties with the exception of those activities that involved heavy lifting. On this record, we conclude that claimant's violation of the employer's heaving lifting rule involved a prohibited overstepping of the boundaries defining his ultimate work. Therefore, we conclude that claimant's injuries occurred outside the course and scope of his employment.

ORDER

The Referee's order dated October 29, 1993 is reversed in part and affirmed in part. The SAIF Corporation's denial is reinstated and upheld in its entirety. The Referee's $2,000 attorney fee award is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MICHAEL S. BARLOW, Claimant
WCB Case Nos. 93-07933 & 93-02579
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
David J. Lillig (Saif), Defense Attorney
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests, and the SAIF Corporation cross-requests, review of those portions of Referee Hoquet's order that: (1) upheld EBI Companies' denial of claimant's "new injury" claim for a L4-5 disc protrusion condition; and (2) "nullified" claimant's aggravation claim and SAIF's denial for the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee, in upholding EBI's denial, found that claimant did not sustain a new back injury as a result of either an ankle twisting incident while working for EBI's insured or an elk hunting trip. Since SAIF had based its aggravation denial on the ground that claimant sustained a new injury while working for a subsequent employer, (a theory rejected by the Referee), the Referee nullified claimant's aggravation claim and SAIF's denial of that claim. The Referee further advised that claimant could pursue a medical services claim against SAIF and/or EBI.

Responsibility

In the responsibility context, ORS 656.005(7)(a)(B) applies to determine whether or not a worker sustained a "new compensable injury" under ORS 656.308. SAIF v. Drews, 318 Or 1 (1993). In Drews, the Supreme Court reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior employer is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer only if the injury is found to be "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the major contributing cause, the Supreme Court further determined that responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

Claimant contends that he suffered a "new injury" on October 20, 1992, while working for EBI's insured, when he stepped out of his garbage truck, twisted his right ankle, and landed on his left hip. EBI contends that claimant injured his low back while on an elk hunting trip in November 1992. The Referee found that claimant did not injure his back during the elk hunting trip. The Referee further found that, although claimant may have twisted his ankle while working for EBI's insured, claimant failed to prove that he fell on his left hip and injured his low back during that incident.

We agree with and adopt the Referee's findings and conclusions that claimant failed to establish that he injured his low back on or about October 20, 1992. Furthermore, even if claimant sustained a low back injury as alleged by claimant, that injury is not the major contributing cause of claimant's current low back condition.

Dr. Wayson, claimant's treating neurosurgeon, opined that both the 1988 injury (with SAIF, which resulted in a L4-5 and L5-S1 discectomy and a 37 percent unscheduled PPD award) and the 1992 injury (with EBI) were partially responsible for claimant's current condition. He explained that following surgery there is weakness in the annulus and that the post-operative site is susceptible to further herniation. (Ex. 117).

Dr. MacKay opined that the October 1992 injury was a contributing cause of the recurrent disc. He could not state that it was the major contributing cause. He felt that it was more than likely that the main contributing cause was the disc that was already weakened from previous events. (Exs. 122, 124).

Dr. Brown, neurologist, and Dr. Bald, orthopedic surgeon, examined claimant on May 11, 1993. Based on claimant's history, they opined that the October 20, 1992 injury, in which he stepped out of his garbage truck and twisted his right ankle and landed on his left hip, was the major contributing cause of claimant's disability and need for treatment. (Ex. 118). We give the opinion of Drs. Brown and Bald little weight because they fail to discuss the contribution from the prior disc herniation, which Drs. Wayson and MacKay found as a contributing cause.

Based on the above, we find that claimant has not sustained a "new compensable injury" while working for EBI's insured. Accordingly, responsibility does not shift to EBI. We proceed to address whether or not claimant established a compensable aggravation claim against SAIF.

Aggravation

SAIF contends that claimant has failed to establish a causal connection between his current condition and the accepted condition, because the current condition is a new condition. SAIF concludes that the new condition resulted from an intervening off-the-job injury or resulted from a subsequent compensable new injury. Under either standard, SAIF must prove major contributing cause. ORS 656.273(1); 656.005(7)(a)(B); 656.308.

Claimant underwent surgery for L4-5 and L5-S1 disc herniations in August 1990, as part of medical treatment for SAIF's accepted claim. Claimant's current low back condition involves a recurrent disc protrusion at L4-5. Accordingly, claimant's current condition is the same condition as the 1988 accepted condition.

Based on the medical evidence (discussed above), we find that the 1988 accepted condition is at least a materially contributing cause of claimant's current condition. Fernandez v. M&M Reforestation, 124 Or App 38 (1993); Roger D. Hart, 44 Van Natta 2189 (1992). We also find that the opinions of Drs. Wayson and MacKay are insufficient to carry SAIF's burden of proof that an intervening injury is the major contributing cause of claimant's current low back condition. Id. SAIF, therefore, remains responsible. Accordingly, the Referee's order nullifying claimant's aggravation claim and SAIF's denial is vacated. SAIF's denial is set aside insofar as it pertains to claimant's claim for medical services.[1]

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's cross-request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $2,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated October 12, 1992 is reversed in part and affirmed in part. In lieu of the Referee's order nullifying SAIF's June 24, 1993 denial, the denial is set aside insofar as it pertains to medical services. The claim for medical services is remanded to SAIF for processing according to law. Claimant's attorney is entitled to a $2,500 assessed attorney fee for services at hearing and on Board review, payable by the SAIF Corporation. The remainder of the Referee's order is affirmed.

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[1] Claimant's claim for aggravation does not include temporary disability, permanent disability, or vocational assistance because those benefits have been released pursuant to a 1991 CDA. Nevertheless, because medical services cannot be released, the Hearings Division and the Board retain jurisdiction to resolve this dispute regarding the causal relationship between claimant's need for medical treatment for his current low back condition and his 1988 compensable injury. In addition, at hearing, claimant stated that he was seeking medical treatment for a recurrent L4-5 disc condition. (Tr. 2). Accordingly, claimant's aggravation claim and SAIF's denial are limited to medical services.

In the Matter of the Compensation of
MICHAEL S. BARLOW, Claimant
WCB Case Nos. 93-14784 & 94-01602
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Neal's order that dismissed claimant's hearing requests concerning claimant's medical services claim with the SAIF Corporation and "new occupational disease" claim with EBI Companies. On review, claimant seeks reversal of the Referee's order and remand for a hearing on the merits of his claims. We deny the request to remand and affirm.

FINDINGS OF FACT

Claimant compensably injured his low back on June 10, 1988 while working for SAIF's insured. SAIF accepted the claim for a left shoulder strain and a low back strain. In August 1990, claimant underwent surgery for L4-5 and L5-S1 disc herniations as part of medical treatment for his accepted claim. The claim was closed with an award of 37 percent unscheduled permanent disability. Claimant subsequently entered into a Claim Disposition Agreement with SAIF in December 1991 and released all future benefits, except medical services.

Claimant began working for EBI's insured in August 1992 as a garbage truck driver. In November 1992, claimant filed a low back injury claim against EBI, which EBI denied on February 17, 1993. The denial stated that "there is insufficient evidence to substantiate any relationship between your low back strain injury and your employment with [the employer]. ORS 656.266 states, 'The burden of proving that an injury or occupational disease is compensable and of providing the nature and extent of any disability resulting thereof is upon the worker ...'"

On March 13, 1993, claimant filed a claim for aggravation of his 1988 claim with SAIF. SAIF issued a disclaimer of responsibility on May 4, 1993 on the ground that claimant's condition and need for treatment may be the result of a separate injury or occupational disease for which EBI may be responsible. SAIF, thereafter, denied the claim on June 24, 1993 stating that it was "unable to pay for [claimant's] current treatment because the June 6, 1988 injury is not the major contributing cause of [claimant's] condition." Rather, SAIF asserted that claimant sustained a new injury which contributed to a worsening of claimant's condition.

Hearing convened before Referee Hoguet on September 30, 1993. On October 12, 1993, Referee Hoguet upheld EBI's February 17, 1993 denial and nullified claimant's aggravation claim and SAIF's June 24, 1993 denial. The Referee upheld EBI's denial on the ground that claimant failed to establish a compensable accidental injury. The Referee nullified claimant's aggravation claim and SAIF's denial, reasoning that claimant had not asserted a medical services claim.

Claimant subsequently filed an occupational disease claim against EBI and a medical services claim against SAIF. Referee Neal dismissed claimant's requests for hearing, finding that claimant was barred by res judicata from bringing his case on a different theory.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that the prior adjudication of his low back claim as an accidental injury does not preclude litigation of the compensability of that condition under an occupational disease theory. In particular, claimant contends that claim preclusion does not apply because finality has not attached to the prior proceeding since Referee Hoguet's order is pending appeal before the Board.

Claim preclusion bars future litigation not only on every claim included in the pleadings, but on every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den, 289 Or 337 (1980). Claim preclusion does not require actual litigation of an issue. However, it does require the opportunity to litigate, whether or not used. Finality is also required. Drews v. EBI Companies, 310 Or 134, 140 (1990). Finality attaches when hearing and Board review rights are barred or exhausted. Id. at 149.

The parties have agreed that this case be consolidated with the appeal of Referee Hoquet's October 1993 order. Thus, although adjudication of the initial claims is not final due to the appeal of Referee Hoguet's order, for reasons of administrative efficiency, we conclude that it was appropriate for Referee Neal to give precedential effect to Referee Hoguet's order.

On review of Referee Hoguet's order, we found that claimant's 1988 accepted condition was materially related to his current low back condition, and that SAIF failed to prove that an intervening injury was the major contributing cause of claimant's current condition. In reaching this conclusion, we have found that SAIF remains responsible for claimant's medical services claim in regard to his current low back condition. Michael S. Barlow, 46 Van Natta 1625 (1994). Our order on review of Referee Hoguet's order is, thus, final for purposes of res judicata. Ronald L. May, 43 Van Natta 843 (1991)(although pending appeal, Board order was final for purposes of res judicata because court does not conduct de novo review of the evidence).

In regard to claimant's occupational disease claim, claimant does not contend that his low back condition is different, or has changed, from his condition at the time of the hearing before Referee Hoguet. Rather, claimant asserts that his condition is a result of an occupational disease caused by his work exposure while working for EBI's insured. The present claim arises out of the same aggregate of operative facts that were alleged under the earlier claim; i.e. claimant's work activities for EBI's insured and its relationship to claimant's need for treatment. Claimant could have asserted the occupational disease theory at the time of the Hoguet hearing. Claimant is therefore precluded from making the occupational disease claim against EBI. Million v. SAIF, supra; Derek J. Schwager, 44 Van Natta 1505 (1992).

Finally, claimant contends that, because Referee Hoguet expressly reserved claimant's right to maintain a second action, there can be no preclusive effect. However, we have vacated that portion of Referee Hoguet's order which nullified claimant's aggravation claim and SAIF's denial and have set aside SAIF's denial, insofar as it pertains to claimant's medical services claim. Thus, claimant's subsequent claim against SAIF is moot.

Because we have found claimant's current claims are barred, we need not remand this case to the Referee.

ORDER

The Referee's order dated March 14, 1994 is affirmed.

In the Matter of the Compensation of
JAMES E. BOGLE, Claimant
WCB Case No. 93-04776
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Nichols' order that upheld the SAIF Corporation's denial of claimant's psychological condition. On review, the issue is compensability.

We adopt and affirm the Referee's order, with supplementation to address claimant's argument on review.

The Referee analyzed claimant's condition under ORS 656.802, the occupational disease/mental disorder statute. On review, claimant contends that his condition was a new condition and should be analyzed as an injury rather than an occupational disease, as its onset was sudden, occurred during a discrete period of time, and was brought on by an identifiable event.

Assuming without deciding whether claimant's condition was a "new condition," we disagree with claimant's analysis. Subsequent to the Referee's order, the Supreme Court issued Dibrito v. SAIF,

319 Or 244 (1994), in which it impliedly construed ORS 656.802 as applying to all initial claims for the independent compensability of a mental disorder. In Dibrito, the claimant, who had preexisting colitis and a preexisting personality disorder, filed a claim for an episode of colitis and psychological symptoms that she alleged had resulted from a specific work incident. The Court held that ORS 656.802 applied to the claim for psychological symptoms and that ORS 656.005(7) applied to the claim for the episode of colitis, despite the fact that both conditions were sudden in onset and allegedly resulted from the same work incident.

Here, claimant is making the same kind of allegation regarding his psychological condition: that it was sudden in onset and resulted from an identifiable event at work. We conclude that the Referee correctly applied ORS 656.802 in this case. See also Fuls v. SAIF, 129 Or App 255 (1994) (Where a worker is trying to establish the independent compensability of a mental disorder, it must be analyzed as an occupational disease under ORS 656.802).

ORDER

The Referee's order dated September 30, 1993 is affirmed.

August 11, 1994 Cite as 46 Van Natta 1629 (1994)

In the Matter of the Compensation of
LEONA M. BROOKS, Claimant
WCB Case No. 93-03591
ORDER OF ABATEMENT
Daniel M. Spencer, Claimant Attorney
Meyers & Radler, Defense Attorneys

The self-insured employer requests reconsideration of our July 13, 1994 Order on Review that affirmed the Referee's penalty award for an unreasonable discovery violation. Additionally, we modified the Referee's order to award an assessed attorney fee for an unreasonable denial. The employer asserts that: (1) there was no basis for a penalty award pursuant to ORS 656.262(10) because the discovery violation did not result in a delay of claimant's compensation; and (2) the employer's denial was not unreasonable because it had legitimate doubt regarding the compensability of claimant's occupational disease claim.

In order to further consider the employer's contentions, we withdraw our July 13, 1994 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, the Board shall proceed with its reconsideration.

IT IS SO ORDERED.

August 11, 1994 Cite as 46 Van Natta 1629 (1994)

In the Matter of the Compensation of
ROBERTO R. CASTILLO, Claimant
WCB Case No. 93-05479
ORDER OF ABATEMENT
Vick & Gutzler, Claimant Attorneys
Lundeen, et al., Defense Attorneys

The insurer requests reconsideration of our July 13, 1994 Order on Review. Specifically, the insurer requests that we affirm the Referee and find claimant's lumbar strain and right trapezius strain not compensable.

In order to further consider this matter, we withdraw our July 13, 1994 order. Claimant is granted an opportunity to respond. To be considered, claimant's response shall be due within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
OLIVER L. JAQUAY, Claimant
WCB Case No. 92-10193
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Davis' order which: (1) upheld the insurer's partial denial of claimant's psychological condition; (2) affirmed the January 28, 1992 Determination Order; (3) declined to award interim compensation; and (4) declined to assess penalties for untimely production of documents, for allegedly failing to pay interim compensation, and for untimely denial of the psychological claim. On review, the issues are compensability, premature claim closure, interim compensation, and penalties.

We adopt and affirm the order of the Referee with the following supplementation.

As the Referee noted, this claim is for benefits for the consequences of a compensable injury rather than an independent claim for occupational disease. Accordingly, claimant must prove that his compensable injury is the major contributing cause of his psychological condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992): Keith J. Prodzinski, 46 Van Natta 290 (1994).

Considering the number of potential causes of claimant's psychological condition, the causation issue is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). In evaluating causation, we rely on those opinions which are well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986).

We agree with the Referee that there are persuasive reasons not to defer to Dr. Dixon's opinion. Dr. Dixon opined that claimant has had his transsexualism disorder for many years and had been functioning adequately until his injury. Dr. Dixon reasoned that the injury and its resulting chronic pain and loss of employment were the only new causative elements, and thus, the injury was the major contributing cause of claimant's current depression. (Ex 170, Tr. 95-98, 105-106). Dr. Dixon's opinion is based entirely on a sequential relationship between claimant's July 1989 elbow injury and his current depression. Given the numerous other identified causes of claimant's psychological condition, a mere temporal relationship is insufficient to prove causation. See ORS 656.266; Allie v. SAIF, 79 Or App 284 (1986); Ruben G. Rothe, 45 Van Natta 369 (1993).

Dr. Dixon also made an incorrect assumption regarding claimant's right elbow condition Rather, the medical evidence, particularly from claimant's treating physician, Dr. Peterson, establishes exaggerated pain behavior, that claimant's elbow condition is minor, that it has not changed since it was found medically stationary in March 1990, that objective findings do not support claimant's subjective complaints, and that the elbow condition does not preclude claimant's return to work. Thus, we discount Dr. Dixon's opinion because it is based on incomplete and inaccurate information. Somers v. SAIF, supra.

Rather, we find persuasive the opinions of Dr. Turco, psychiatrist, and Dr. Davis, psychologist, which relate claimant's depression to his sexual identity disorder, personality disorder, and substance abuse.

Dr. Turco opined that claimant's psychological problems were associated with multiple causes, including alcohol and marijuana abuse, anger about not being able to return to his occupation as a cook, anger towards the vocational consultant, multiple disappointments at different jobs, unresolved rage towards his natural father and stepfather, and psychosexual confusion and attempts to become a woman. (Exs. 153, 173-44). After review of additional medical records, Dr. Turco opined that there was no evidence that claimant's physical condition resulting from his 1989 industrial injury or its sequelae caused or contributed to any of his psychological problems. Dr. Turco concluded that the major contributing cause of claimant's depression was his preexisting psychological problems, including sexual identity issues. (Exs. 172, 173-45).

Dr. Turco explained that a temporal relationship does not necessarily relate claimant's injury as a cause of the depression for a number of reasons. These reasons included claimant's core identity problems which are productive of depression, and the medical records indicating that claimant has been medically stationary since March 1990 and that claimant could return to work. (Ex. 173 p. 47-48).

Dr. Davies, clinical psychologist, performed a psychological evaluation as well as observed the medical examination performed by Dr. Kiest, orthopedic surgeon, and Dr. Phipps, neurologist, which revealed multiple nonorganic pain findings and symptom magnification. Dr. Davies concluded that claimant's psychological problems were longstanding and rooted in his biological depression, his personality disorder, substance abuse, and his sexual identity disorder. (Exs. 167, 174 p. 60-62, 75).

Accordingly, we agree with the Referee that claimant has failed to carry his burden of proving a compensable psychological condition.

ORDER

The Referee's order dated November 24, 1993 is affirmed.

August 11, 1994 Cite as 46 Van Natta 1631 (1994)

In the Matter of the Compensation of
KENNETH W. MATLACK, Claimant
WCB Case No. 93-10533
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Hazelett's order which declined to award additional scheduled permanent disability beyond the award of 5 percent (9.6 degrees) scheduled permanent disability granted by an Order on Reconsideration for loss of use or function of claimant's left arm. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of his "ultimate findings of fact."

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable cervical strain on September 2, 1992, for which he subsequently underwent cervical surgery. Claimant's attending physician, Dr. Parsons, conducted a closing examination on January 29, 1993. He reported that claimant's cervical range of motion was full, but that claimant had reduced grip strength in his left hand and that sensory examination revealed subjective hypesthesia in the left thumb and index finger. Dr. Parsons rated claimant's two-point discrimination at 7 to 10 millimeters and his grip strength at 3/5 due to compensable cervical nerve root injury.

Based on this examination, a March 19, 1993 Determination Order awarded claimant 9 percent unscheduled permanent disability based on claimant's cervical surgery. The Determination Order also awarded 26 percent scheduled permanent disability for claimant's left arm based on decreased grip strength and loss of sensation.

While unrepresented, claimant requested reconsideration. Dr. Dinneen performed a medical arbiter's examination in which he reported claimant's grip strength as normal and his two-point discrimination at 6 millimeters in all fingers. Dr. Dinneen stated that claimant did have a mild inability to repetitively use his left arm.

The Order on Reconsideration reduced claimant's scheduled permanent disability award to 5 percent for a "chronic condition" and increased the unscheduled permanent disability to 28 percent. Claimant requested a hearing regarding the extent of scheduled permanent disability.

The Referee affirmed the award of scheduled permanent disability in the Order on Reconsideration, finding the arbiter's report more persuasive than Dr. Parsons' closing examination concerning the extent of claimant's permanent impairment in his left arm. The Referee reasoned that he must rely on the arbiter's examination unless there were persuasive reasons to disregard it. Inasmuch as the arbiter's examination was conducted closer in time to the reconsideration order and based on claimant's credible description of his symptoms, the Referee chose to rely on the arbiter's examination instead of Dr. Parsons' closing report.

On review, claimant contends that the Board should rely on Dr. Parson's closing report and reinstate the award of scheduled permanent disability granted in the Determination Order. We agree.

We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. See Raymond L. Owen, 45 Van Natta 1528 (1993) (Impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993). In this case, we find Dr. Parsons' closing examination to constitute the most thorough and accurate evaluation of claimant's permanent impairment.

Dr. Parsons measured claimant's grip strength with a dynamometer. (Ex. 7). There is no indication in Dr. Dinneen's report about how he determined that claimant's grip strength was normal. (Ex. 12-2). This case is similar to Timothy W. Reintzell, 44 Van Natta 1534, 1535 (1992), where we relied on the grip strength findings of the attending physician, who conducted grip strength tests, rather than the findings of the medical arbiter, who merely conducted a clinical examination. Accordingly, we find Dr. Parsons' evaluation of claimant's grip strength to be more accurate and, hence, more persuasive than Dr. Dinneen's. Thus, claimant is entitled to a value of 18 for loss of strength. See OAR 436-35-007(7).

With respect to loss of sensation findings, there is little difference between Dr. Parsons' closing report and Dr. Dinneen's arbiter's examination. However, we adopt Dr. Parsons' finding of two-point discrimination at 7 to 10 millimeters because it more closely corresponds to claimant's credible testimony that his sensory complaints have continued since Dr. Parsons' closing examination. (Tr. 9, 12, 13). Therefore, claimant is entitled to a value of 10 for loss of sensation. See OAR 436-35-110(1)(b).

Finally, we note that the reconsideration order awarded 5 percent scheduled permanent disability for a "chronic condition," based on Dr. Dinneen's arbiter's examination. Since claimant urges us to rely on Dr. Parsons' closing examination in rating his scheduled permanent disability, and Dr. Parsons did not report a limitation on claimant's ability to repetitively use his left arm, we do not find that claimant is entitled to a 5 percent "chronic condition" award.

In conclusion, we find Dr. Parsons' closing examination to be the most persuasive evaluation of claimant's injury-related permanent impairment because it is thorough, accurate and most compatible with claimant's credible testimony of ongoing symptomatology. Thus, we adopt it in rating claimant's permanent impairment. Inasmuch as SAIF does not dispute that the Determination Order correctly rated claimant's scheduled permanent disability based on Dr. Parsons' closing report, we reinstate the scheduled award granted by the Determination order.

Because we have reinstated the scheduled award made by the Determination Order, our order results in increased compensation. Therefore, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation (21 percent scheduled permanent disability; the difference between the Order on Reconsideration's 5 percent award and the Determination Order's 26 percent award). ORS 656.386(2); OAR 438-15-040(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994).

ORDER

The Referee's order dated January 12, 1994 is modified. In lieu of the Referee's and Order on Reconsideration's awards of scheduled permanent disability, the award of 26 percent (49.92 degrees) scheduled permanent disability for loss of use or function of claimant's left arm, as granted by the

March 19, 1993 Determination Order, is reinstated and affirmed. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation (21 percent scheduled permanent disability) created by this order, not to exceed $3,800. In the event that this increased compensation has already been paid to claimant, claimant's attorney is authorized to seek recovery of the fee in the manner prescribed in Jane Volk, supra.

In the Matter of the Compensation of
MAUREEN H. McCARTHY, Claimant
WCB Case No. 93-12902
ORDER ON REVIEW (REMANDING)
Welch, Bruun, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Thye's "Order of Dismissal," which dismissed claimant's November 2, 1993 request for hearing appealing the SAIF Corporation's October 25, 1993 disclaimer of responsibility. On review, the issue is the propriety of the Referee's dismissal order. We vacate the Referee's order and remand.

FINDINGS OF FACT

On September 15, 1993, claimant filed a claim for injuries to her right hand and left wrist allegedly due to her employment for SAIF's insured. On October 25, 1993, SAIF issued a notice of disclaimer, identifying Liberty Northwest Insurance Corporation and its insured as responsible for claimant's injuries. On November 2, 1993, claimant filed a request for hearing raising the issues of compensability, responsibility, medical services and attorney fees and specifying the date of the denial as October 25, 1993.

SAIF moved to dismiss claimant's request for hearing as premature on December 23, 1993. On January 5, 1994, claimant filed a supplemental request for hearing against SAIF, raising the issue of "de facto" denial. Claimant also enclosed a copy of a request for hearing against Liberty and its insured. Claimant's supplemental hearing request was combined with the file containing claimant's earlier hearing request.

On January 12, 1994, the Referee issued a "Order of Dismissal." Reasoning that, pursuant to Gamble v. Nelson International, 124 Or App 90 (1993), SAIF's disclaimer notice was not a denial, the Referee concluded that claimant's November 2, 1993 request for hearing was premature. Thus, the Referee dismissed claimant's November 1993 hearing request. The Referee then consolidated claimant's supplemental request for hearing with her hearing request against Liberty Northwest and directed that a new hearing date be established. The Referee's order contained a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3).

Within 30 days of the Referee's order, claimant filed a request for Board review.

CONCLUSIONS OF LAW AND OPINION

Claimant's November 1993 hearing request may have been premature. See Gamble v. Nelson International, supra; Syphers v. K-W Logging Inc., 51 Or App 769 (1981). However, prior to its dismissal, claimant supplemented that request for hearing with another request which raised the issue of "de facto" denial. Such supplements are freely allowed up to the time of hearing. See OAR 438-06-031. Inasmuch as the so-called "premature" hearing request was supplemented with the later hearing request, we disagree with the Referee's decision to dismiss claimant's request for hearing concerning SAIF by means of a final, appealable order. We reach such a conclusion because the Referee's order did not finally dispose of claimant's claim with SAIF.

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision that neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986).

In this case, the Referee's order neither finally disposed of, nor allowed the claim against SAIF. In addition, the order did not fix the amount of claimant's compensation. Rather, the order was preliminary in nature in that it notified claimant and SAIF that these proceedings would be consolidated with those involving Liberty Northwest. Although it dismissed one of claimant's hearing requests, the Referee's order specifically deferred action regarding claimant's claim against SAIF pending a rescheduling for hearing.

Inasmuch as the Referee's order pertained to pre-hearing matters, and since the order directed the rescheduling of a hearing regarding claimant's claim against SAIF for consolidation with her hearing request concerning her Liberty Northwest claim, we hold that the order was not final. See Joseph C. Hackler, 45 Van Natta 1450, 1451 (1993). This decision is not only consistent with Board precedent, but it is also in accordance with Board policy to avoid piecemeal review of multiple issues arising from the same claim through use of "interim orders." See Diana L. Brett, 46 Van Natta 23, 23 (1994); Joseph C. Hackler, supra.

An interim order not only avoids the potential for piecemeal review of "preliminary orders," but it also allows the parties to be notified of the Referee's pre-hearing rulings while permitting a formal dismissal of a request for hearing to be incorporated in the Referee's eventual final appealable order. Diana L. Brett, supra. Consistent with the aforementioned policy and rationale, such an approach satisfies the parties' primary concerns (SAIF's concern being dismissal of an allegedly premature hearing request; claimant's concern being the avoidance of concurrent proceedings before the Board and the Hearings Division) while simultaneously avoiding the potential for piecemeal litigation.

In conclusion, although not framed as an interim order, we interpret the Referee's order as interim in nature. Joseph C. Hackler, supra. As a result of the Referee's order, further proceedings will be necessary to determine claimant's entitlement to, and/or the amount of, compensation. Under these circumstances, notwithstanding the statement regarding the parties' rights of appeal, the Referee's order is not a final appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra; Joseph C. Hackler, supra.

Accordingly, the Referee's order is vacated. This case is remanded to Referee Thye for further action consistent with this order and the Referee's January 12, 1994 order. That is, the consolidation of this WCB case number with the other pending hearing requests (and WCB case numbers) and the scheduling/convening of a hearing involving SAIF, Liberty Northwest and claimant. Referee Thye's eventual final order will incorporate by reference his January 12, 1994 Order of Dismissal.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARL J. SIGMAN, Claimant
WCB Case No. 93-12038
ORDER ON REVIEW
William A. Mansfield, Claimant Attorney
Betsy F. Byers (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Mongrain's order that set aside its denial of claimant's left leg myoclonic jerk condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Based on his reading of the reports of Drs. Mersch, Maukonen and Kho, the Referee concluded that claimant had established that his left leg myoclonic condition was caused, in major part, by the compensable back injury he sustained in December 1992. We disagree.

The parties agree that this case is governed by ORS 656.005(7)(a)(A). Accordingly, to prevail, claimant must establish that his compensable back injury was the major contributing cause of his left leg myoclonic condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We conclude that claimant has not met that burden of proof.

Claimant relies on the reports of Drs. Mersch and Maukonen, treating physicians, and Dr. Kho, examining physician, to prove the compensability of his claim. We conclude that none of those physicians' reports is sufficient to meet claimant's burden.

Dr. Mersch concludes that, because claimant's myoclonic condition did not appear until after he injured his back in 1992, "there seems to be a causal relationship" between the myoclonic condition and the back injury. (Ex. 42A). Similarly, Dr. Maukonen stated: "By history I have, [the myoclonic jerks] began shortly after his [1992] accident. * * * I feel they are most likely, therefore, related to his accident." (Ex. 42B).

We are not persuaded by either Dr. Mersch's or Dr. Maukonen's opinions. Neither physician concludes that it is medically probable that the major cause of claimant's myoclonic condition was his compensable back injury. Although "magic words" are not necessary to establish causation, see Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992), on this record, we conclude that the doctors' unquantified statements that there "seems to be" or is "most likely" a relationship between claimant's myoclonic condition and his back injury fall short of meeting claimant's burden.

Furthermore, both Dr. Mersch and Dr. Maukonen rely almost solely on the temporal relationship between claimant's 1992 work accident and the onset of claimant's left leg jerking in concluding that claimant's myoclonic condition was compensably related to his back injury. Because such a relationship will not, by itself, satisfy claimant's burden of proof, we afford Drs. Mersch's and Maukonen's opinions minimal probative weight. Pamela A. Burt, 46 Van Natta 415 (1994); see ORS 656.266.

We reach the same conclusion regarding Dr. Kho's report. He concluded that claimant had nonphysiologic myoclonic jerks; however, he did not render an opinion regarding the cause of that condition. (Ex. 45). Accordingly, we give his report no weight.

Instead, we rely on the reports of Dr. Dickerman, examining physician. After extensively reviewing claimant's history, conducting a physical examination and considering the pathophysiology of

several myoclonic disorders, Dr. Dickerman concluded that claimant's leg jerking was a factitious disorder, possibly prompted by secondary gain. (Ex. 34-19).[1] Dickerman then ruled out a cerebellar or brainstem abnormality that could have produced claimant's leg jerking, and concluded that there was no reasonable explanation for claimant's leg jerking. (Id.) In a supplemental opinion, he concluded that claimant's 1992 back injury would not have produced the type of clonic activity claimant has displayed. (Ex. 44-2).

On this record, we find Dr. Dickerman's reports persuasive evidence that claimant's left leg myoclonic condition was not caused by his 1992 compensable back injury. Accordingly, we reverse the Referee's decision setting aside SAIF's denial of that condition.

ORDER

The Referee's order dated February 8, 1994 is reversed. The SAIF Corporation's denial is reinstated and upheld in its entirety. The Referee's attorney fee award is also reversed.

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[1] There is considerable conflict in the medical evidence regarding whether claimant's myoclonia is real or factitious. There is also conflicting evidence regarding claimant's diagnosis. The Referee concluded that, based on Dr. Kho's report, claimant had established that he had a hysterical conversion. We disagree. Other than a conclusory statement in Kho's report stating that claimant had "[h]ysterical conversion reaction to myoclonic jerks," (Ex. 45-4), there is no other mention of hysterical conversion in the record. Furthermore, we are not sure if Dr. Kho's diagnosis means that he believes that claimant has developed a hysterical conversion that has manifested itself through the myoclonic condition, or that claimant's myoclonic condition has, though the hysterical conversion phenomenon, led to the manifestation of other physical problems.

Board Member Hall concurring.

I write separately to express the following view: In this and other cases, this Board seems to give lip service to the "no need for magic words" rule enunciated in McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) and Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992). That is, we have a tendency to mention the rule and then to reject medical opinions that fail to mimic the applicable statutory standard.

It is this Board's duty, not the medical experts', to determine whether the evidence, as a whole, meets the claimant's burden of proof. Based on the most persuasive, well-reasoned medical explanation, we are to determine whether work is a material or the major cause of the claimed condition.

The problem with the present case is the lack of a persuasive medical explanation from which we can conclude that claimant has met his burden of establishing the compensability of his myoclonic condition. Lacking that explanation, we are left only with a temporal relationship between claimant's work injury and the onset of his left leg myoclonic condition.[1] I agree that such a relationship, alone, will not meet claimant's burden of proof. E.g., Pamela A. Burt, 46 Van Natta 415 (1994); see ORS 656.266.

In this case, there is a failure of proof regarding the cause of claimant's myoclonia. I am not sure our reference to the "magic words" analysis is either necessary or persuasive under these, or perhaps any, circumstances. Instead, I would prefer to focus on whether there is sufficient evidence, in the record as a whole, to meet the statutory standard, without regard to whether a medical opinion is (or is not) couched in the applicable "magic words."

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[1] A perfect example of this is the report of Dr. Kho, who offers a diagnosis (hysterical conversion reaction to myoclonic jerks), but no explanation for that diagnosis. (Ex. 45-4).

In the Matter of the Compensation of
MERRY E. FRANKLIN, Claimant
WCB Case No. 92-14761
ORDER ON RECONSIDERATION
Willner & Heiling, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Claimant requests review of our March 8, 1994 order which denied claimant's request for reconsideration of our December 30, 1993 order that vacated a Director's vocational assistance order and remanded for consideration of a temporary rule. Contending that we erroneously ruled that we lacked jurisdiction to alter our December 30, 1993 order, claimant repeats her prior request that we effect a remedy where the Director has rejected our remand order.

We begin with a brief summary of the relevant facts. While locked out from her employment as a bus driver, claimant was compensably injured while working as a temporary shuttle driver for another employer. As a result of her injury, claimant was physically unable to return to bus driving activities. When the self-insured employer rejected her subsequent request for vocational assistance, claimant sought Director review. The Director denied her request, reasoning that she had not established a "substantial handicap to employment." See ORS 656.340(6)(b)(B)(iii). In reaching this conclusion, the Director applied OAR 436-120-025(1)(b), which pertains to a worker whose customary employment is periods of seasonal or temporary employment followed by periods of unemployment. The Referee affirmed the Director's order.

In our December 30, 1993 order, we found that, since claimant's only temporary work was that as the shuttle driver, her "customary" employment "pattern" was not seasonal or temporary employment followed by periods of unemployment as described in OAR 436-120-025(1)(b). Merry E. Franklin, 45 Van Natta 2441 (1993); deny recon 46 Van Natta 374 (1994). Determining that there was no rule regarding the calculation of claimant's base wage which applied to her situation, we noted that OAR 436-120-025(2) provides that the Director may prescribe additional standards for establishing a base wage. In light of such circumstances, we held that the Director had violated a rule by applying OAR 436-120-025(1)(b). See ORS 656.283(2). Moreover, relying on Gallino v. Courtesy Pontiac-Buick-GMC, 124 OR App 538, 542 (1993), we reasoned that we had implicit authority to remand the claim to the Director for consideration of adoption of a rule under OAR 436-120-025(2).

Neither party petitioned the Court of Appeals for judicial review of our decision. Instead, on February 1, 1994, the Director (through the Workers' Compensation Division) announced that the Department "has not accepted jurisdiction over this matter." Contending that the Board has the authority "to effect a remedy," the Department "respectfully disagree[d] with the position that the Workers' Compensation Board has the authority to remand a case to the Director." In light of the Department's announcement, claimant requested "that the Board resume jurisdiction of this case and effect a remedy for claimant."

On March 8, 1994, we denied claimant's request. Reasoning that our December 30, 1993 order had become final, we held that we were without authority to alter our prior decision. Nevertheless, we interpreted the Director's February 1, 1994 announcement as an order declining to adopt a temporary rule and a decision adhering to the Director's previous vocational assistance order. Inasmuch as claimant was seeking relief from that February 1, 1994 decision, we interpreted claimant's request as a request for hearing. Consequently, we directed the Hearings Division to assign a new WCB Case Number to the request and schedule the matter for a new hearing.

Claimant now seeks further consideration of this matter. Reasoning that our December 30, 1993 remand order was not a final order, claimant reasserts that we retain authority to reconsider it.

After further examination of this procedural issue, we conclude that our December 30, 1993 remand order was not a final, appealable order. Specifically, the order neither finally determined claimant's entitlement to compensation, or the amount thereof. See Price v. SAIF, 296 Or 311 (1984) (A final order is one which disposes of a claim so that no further action is required); Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974) (A decision which neither denies the claim, nor allows it and fixes the amount of compensation is not an appealable final order); Robert I. Shewey, 45 Van Natta 2123 (1993) (Referee's order neither finally disposed of, nor allowed, a claim. Furthermore, the order did not fix the amount of the claimant's compensation and, therefore, the order was not final.

Having concluded that our December 30, 1993 order was not final, we also reexamine our prior determination that the Director's February 1, 1994 announcement constituted an order. As we noted in our previous decision, the lack of a statement explaining the parties' rights of appeal from a decision does prevent a party from contesting that decision. See Glen D. Roles, 42 Van Natta 68 (1990) (The lack of a statement explaining the parties' rights of appeal from a referee's order did not invalidate that order.) Nonetheless, after further consideration of this matter, we conclude that our prior interpretation of the Director's announcement was too broad.

The announcement neither explicitly nor implicitly reconsiders the Director's prior vocational assistance order. To the contrary, in disagreeing with our December 30, 1993 order, the Director reasons that the "Board has the power to effect a remedy." Consequently, the Director concludes that "the Department has not accepted jurisdiction over this matter."

Such circumstances establish that the Director continued to adhere to the Department's prior vocational assistance decision. However, in doing so, the Director neither reconsidered nor republished the Department's previous decision. Rather, the Director specifically refused to accept jurisdiction over our remand order.

Accordingly, on reconsideration, we find that the Director's announcement should not be characterized as an order. Therefore, since our December 30, 1994 order was not a final order and because the Director neither re-accepted jurisdiction over the case nor issued another order, we hold that authority over this vocational assistance dispute remains with this forum.

Having concluded that we retain jurisdiction over this matter, we proceed with a further review of the merits.

In order to determine whether claimant is entitled to vocational assistance, we must first determine what constitutes "suitable employment" in claimant's case. "Suitable employment" is defined as employment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment. ORS 656.340(6)(b)(B)(iii); OAR 436-120-005(6)(a)(A). "Regular employment" means employment of the kind the worker held at the time of the injury or the worker's "customary employment." OAR 436-120-005(6)(b). "Customary employment" is the worker's regular employment when it is other than the job at injury, and is the primary means by which the worker earns a livelihood. Id. For other than full-time, permanent employment, a suitable wage is determined pursuant to OAR 436-120-025. OAR 436-120-005(6)(a)(B).

Here, the record establishes that claimant was "locked-out" from her regular, permanent job as a Greyhound bus driver. Claimant had worked for the employer since 1988 until she was replaced during a labor dispute in 1990. At the time of injury, claimant was working as a temporary shuttle bus driver, rather than performing her customary employment as a permanent Greyhound bus driver.

After reviewing the record, we conclude that the temporary shuttle bus driving job held by claimant at the time of her injury was not her regular employment. Instead, the evidence establishes that, but for the lock-out, claimant would have continued to work as a permanent Greyhound bus driver. Therefore, claimant's "regular" or "customary" employment as a Greyhound bus driver was other than the job at injury and was the primary means by which she earned her livelihood.

Accordingly, because claimant's customary or regular employment was that of a Greyhound bus driver, "suitable employment" for claimant is employment that produces a wage within 20 percent of that currently being paid for such employment as a permanent, professional bus driver. ORS 656.340(6)(b)(B)(iii).

Given the fact that claimant's regular or customary job was not the temporary job at which she was injured, we conclude that the Director erred by applying OAR 436-120-025(1)(b) to calculate claimant's base wage. That is, the factual situation in this case did not warrant application of OAR 436-120-025(1)(b), which is to be applied when the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected. (Emphasis supplied).

Here, the record pertaining to claimant's employment history or pattern establishes that the temporary shuttle bus job was claimant's only temporary employment. Moreover, as explained above, her customary employment was that of a permanent full-time bus driver. Therefore, we conclude that the Director violated ORS 656.340 by relying on OAR 436-120-025(1)(b) to determine claimant's suitable wage. See ORS 656.283(2)(a). Instead, we find claimant's base wage from which to calculate a suitable wage to be claimant's wage of $630 per week as a Greyhound bus driver.

In his order denying vocational assistance, the Director found that, following her injury, claimant had the physical ability to perform sedentary, light and light/medium work. He further found that a wide variety of entry-level, physically suitable jobs existed within reasonable commuting distance for claimant. Therefore, after calculating claimant's wage under OAR 436-120-025(1)(b), the Director concluded that a suitable wage for claimant was $4.75.

Consequently, in modifying the Director's order and using a base wage of $630 per week to calculate suitable employment, claimant would have a substantial handicap to employment. Claimant is now limited to work paying the minimum wage, which is not within 20 percent of the wage currently being paid for employment which was claimant's regular employment. See, e.g., Reyna R. Rolban-Duenez, 46 Van Natta 865, 869 (1994). Therefore, we find that the eligibility prerequisites of ORS 656.340 have been satisfied. See ORS 656.340(6)(a) and (b)(B)(iii); OAR 436-120-005(6)(a)(A); OAR 436-120-005(10). Accordingly, because the Director's order found that claimant was not eligible for vocational assistance, the order must be modified. ORS 656.283(2).

As a final note, we recognize that WCB Case No. 94-02712 is currently pending before the Hearings Division as a result of our earlier decisions. While WCB Case No. 94-02712 is not before us, it should be noted that our decision herein reverses the holding which gave rise to claimant's second request for hearing and the creation of WCB Case No. 94-02712.

On reconsideration, therefore, we modify the Referee's order dated February 5, 1993. The Director's order is also modified to direct the insurer to provide claimant the vocational assistance she would receive based on her regular, customary work as a Greyhound bus driver, consistent with this order. The claim is remanded to the insurer for further action consistent with this order.

Inasmuch as this order has resulted in increased compensation, claimant's attorney is awarded 25 percent of that increase, not to exceed $3,800, payable directly to the attorney from the insurer. ORS 656.386(2); OAR 438-15-005(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES McGOUGAN, Claimant
WCB Case Nos. 93-07721, 93-06202 & 93-09283
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband, and Haynes.

Liberty Northwest Insurance Corporation, on behalf of Jewell Manufacturing Company, requests review of that portion of Referee Thye's order which found it responsible for an insurer-paid attorney fee under ORS 656.386(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his "Finding of Ultimate Fact" that Liberty/Jewell is responsible for payment of an assessed attorney fee.

CONCLUSIONS OF LAW AND OPINION

The issue at hearing was responsibility for claimant's bilateral carpal tunnel syndrome. Three employers were involved in the proceedings: Pierce-Pacific (hereinafter "Pierce"), whose claims were processed by AIAC; Fought and Company (hereinafter "Fought"), insured by Liberty Northwest; and Jewell Manufacturing Company (hereinafter "Jewell"), also insured by Liberty Northwest.

Both AIAC/Pierce and Liberty/Fought denied compensability and responsibility initially, but later conceded compensability at hearing. Liberty/Jewell issued a denial on May 18, 1993, in which it stated that claimant's claim was compensable and that it was only denying responsibility. (Ex. 69a). The denial letter also stated that a paying agent pursuant to ORS 656.307 would be requested. Although a paying agent was requested, no ".307" order was ever issued. The Liberty/Jewell denial further recited that it was a "Denial of Your Claim for Benefits" and contained notice-of-hearing provisions.

The Referee found that Liberty/Jewell was responsible for the bilateral carpal tunnel claim. Interpreting Liberty/Jewell's denial as raising an issue of compensability, the Referee also determined that Liberty/Jewell was responsible for payment of an assessed attorney fee under ORS 656.386(1) for claimant's counsel's efforts in obtaining withdrawal of the compensability portion of its denial prior to hearing. See Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994).

On review, Liberty/Jewell contends that it never denied compensability and, therefore, should not be responsible for payment of an assessed attorney fee. We agree.

In Johnny M. Davis, 45 Van Natta 2282 (1993), the insurer rescinded a responsibility disclaimer. We held that the claimant was entitled to an insurer-paid attorney fee under ORS 656.386(1) because the insurer's responsibility disclaimer raised a compensability issue. 45 Van Natta at 2283. The disclaimer stated that it was a denial of claimant's claim for benefits and contained "notice of hearing" provisions. The disclaimer also stated that the insurer was not waiving other issues of "compensability."

More recently, in Linda K. Ennis, 46 Van Natta 1142, 1143 (1994), we cited Davis in determining that a "Disclaimer of Responsibility and Claim Denial" raised an issue of compensability, thereby entitling claimant to an assessed attorney fee pursuant ORS 656.386(1) for her counsel's efforts in obtaining rescission of the compensability denial. In Ennis, there is no indication that the carrier's denial expressly addressed the issue of compensability. The disclaimer/denial letter also contained notice of hearing provisions, as well as a statement that it was a denial of a claim for benefits. In addition, the letter expressly stated that designation of a paying agent had not been requested.

Although the denial in this case is similar in some respects to those in Davis and Ennis, we do not find that Liberty/Jewell raised a compensability issue in its May 18, 1993 denial. Unlike Davis and Ennis, the denial specifically contained an acknowledgment that the claim was compensable. It also stated that only responsibility was being denied. In addition, the denial letter stated that a paying agent would be requested. In fact, a paying agent was requested by Liberty/Jewell. (Ex. 70). Unlike the denial in Davis, there was no language in Liberty/Jewell's denial concerning waiver of compensability issues.

While Liberty/Jewell's denial did contain notice of hearing provisions and stated that it was a denial of benefits, we decline to construe the denial as one of compensability in light of the express language conceding compensability and specifically denying responsibility only. See also Angela M. Stratis, 46 Van Natta 816, 817 (1994) (where claimant acknowledged denial was only related to responsibility, denial construed as limited to responsibility despite inclusion of notice of hearing provisions). To otherwise construe the denial would do violence to the plain meaning of the document.

In summary, we find Davis and Ennis distinguishable and conclude that Liberty/Jewell's denial did not raise an issue of compensability. Accordingly, we reverse that portion of the Referee's order which found Liberty/Jewell responsible for the payment of an assessed attorney fee. The issue then becomes whether claimant is entitled to an assessed attorney fee from the other parties involved in these proceedings.

It is undisputed that AIAC and Liberty/Fought denied compensability and responsibility. Moreover, at hearing, both parties conceded that claimant's carpal tunnel condition is compensable.

Under these circumstances, we find that claimant's attorney was instrumental in obtaining concessions of compensability from AIAC and Liberty/Fought. We conclude, therefore, that claimant is entitled to a carrier-paid attorney fee for his counsel's efforts in obtaining the withdrawal of the compensability portions of AIAC's and Liberty/Fought's denials prior to hearing. Penny L. Hamrick, supra. We further conclude that counsel is entitled to a separate attorney fee for each rescission. See John W. Wantowski, 46 Van Natta 1158 (1994); Dale A. Karstetter, 46 Van Natta 147 (1994).

Both AIAC and Liberty/Fought contend that the Referee's award of $7,500 assessed attorney fee, payable by Liberty/Jewell, was excessive. They assert that, if they are responsible for claimant's attorney fee, the total award should be reduced. We disagree.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $3,750 is a reasonable assessed attorney fee for claimant's counsel's services concerning each rescission of the compensability portions of the denials issued by AIAC and Liberty/Fought. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the hearing record and claimant's counsel's affidavit of services), the complexity of the issues presented, the risk that claimant's counsel might go uncompensated, and the value of the interest to claimant.

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to an attorney fee for services on Board review. State of Oregon v. Hendersott, 108 Or App 584 (1991); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated January 26, 1994 is reversed. That portion of the Referee's order which ordered Liberty/Jewell to pay claimant an assessed attorney fee of $7,500 is reversed. In lieu of the Referee's award of $7,500, claimant's attorney is granted two separate attorney fee awards of $3,750, one award payable by AIAC and one award payable by Liberty/Fought. The remainder of the order is affirmed.

Board Member Haynes concurring in part and dissenting in part.

Although I agree with the majority that Liberty/Jewell should not be responsible for an assessed attorney fee under ORS 656.386(1), I believe the amount of the attorney fees assessed against the other parties is clearly excessive and should be significantly reduced. Accordingly, I depart from the majority's opinion with respect to the total amount of the attorney fee awarded to claimant's counsel.

The majority's approval of a $7,500 attorney fee reflects its unwillingness to become entangled in an attorney-fee dispute. Ordinarily, I do not advocate second-guessing a referee's attorney-fee award unless it is clearly unreasonable. However, I believe that this is one of those instances where the Referee's award was unreasonable.

The only issue at hearing was responsibility for claimant's carpal tunnel syndrome. Granted, the hearing was somewhat longer than usual and there were multiple parties involved. Nevertheless, the primary benefit to claimant was achieved prior to hearing when claimant convinced AIAC and Liberty/Fought to rescind their compensability denials. Moreover, the responsibility issue was not extraordinarily complex. It involved a relatively routine application of the "Last Injurious Exposure Rule." Certainly the responsibility issue was not so complicated that an attorney fee of $7,500 is justified.

Considering all the factors in OAR 438-15-010(4), I would award a total attorney fee of no more than $4,000, with AIAC and Liberty/Fought each paying one-half of the total amount. Because the majority awards an attorney fee greatly in excess of what is reasonable in this case, I respectfully dissent.

In the Matter of the Compensation of
MARK OSTERMILLER, Claimant
WCB Case No. 93-04010
ORDER DENYING ABATEMENT
Michael B. Dye, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

On July 25, 1994, we received the self-insured employer's request that we abate our July 21, 1994 order. In its request, the employer stated that its motion for reconsideration would be filed within 10 days. To date, we have received no further communication from the employer.

A request for reconsideration of a Board order shall include a concise statement of the reason(s) reconsideration is requested. OAR 438-11-035(2). The employer has not expressly moved for reconsideration of our order. Instead, the employer seeks abatement of our decision for purposes of reviewing its motion for reconsideration.

Since the employer's abatement motion is based on an allegedly forthcoming reconsideration motion and because we have not received a concise statement explaining the reason reconsideration is requested, we deny the employer's request for abatement. The parties' rights of appeal shall continue to run from the date of our July 21, 1994 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA A. LEONARD, Claimant
WCB Case No. 90-10644
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Priscilla M. Taylor, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Podnar's order that: (1) upheld the self-insured employer's aggravation denial for a left foot injury; (2) declined to grant permanent total disability; (3) increased claimant's scheduled permanent disability award for the loss of use or function of the left leg from 10 percent (15 degrees) to 14 percent (21 degrees); and (4) declined to increase claimant's unscheduled permanent disability award of 27 percent (86.4 degrees) for a psychological condition. On review, the issues are aggravation, permanent total disability, and, alternatively, extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following addition.

On April 1, 1991, Dr. Berselli performed a diagnostic arthroscopy of the left knee.

The employer paid claimant temporary disability for the period from May 8, 1991 through August 14, 1991, and then denied a claim for aggravation on August 14, 1991. (Exs. 66, 67).

CONCLUSIONS OF LAW AND OPINION

In 1983, claimant compensably injured her left knee. In 1984, she began psychological treatment. In October 1986, a Determination Order issued awarding 15 percent unscheduled permanent disability for claimant's psychological condition and 10 percent scheduled permanent disability for claimant's left knee condition. After a reopening, the claim again closed with a July 1990 Determination Order that increased claimant's unscheduled permanent disability to 27 percent.

Aggravation

Claimant first objects to the Referee's conclusion that she did not prove a compensable aggravation of her left knee claim. Claimant asserts that, while recuperating from her April 1991 arthroscopy, she sustained a "temporary worsening." Claimant relies on a "check-the-box" report from her treating orthopedic surgeon, Dr. Berselli, indicating agreement that "the 4/1/91 arthroscopy represent[ed] a temporary surgical worsening of claimant's condition" and "incapacitate[d] claimant until 10/28/91." (Ex. 96).

Even assuming that such evidence shows that claimant's symptoms increased following the April 1991 arthroscopy, we find it insufficient to prove increased loss of use. First, the report defined "incapacitate" as "how long til [claimant] got back to her pre-arthroscopy condition." Thus, we find that the report indicates only that claimant's condition was different following the procedure without demonstrating in particular that claimant had less ability to use her left knee. Furthermore, shortly after performing the surgery, Dr. Berselli reported that claimant's condition had not changed since a January 24, 1991, examination. (Ex. 69).

Therefore, finding no persuasive proof that claimant sustained an increased loss of use as a result of the April 1991 arthroscopy, we agree with the Referee that she failed to prove a compensable aggravation of her left knee condition. See ORS 656.273(1); Fred Meyer, Inc. v. Farrow, 122 Or App 164, 167 (1993).

Permanent Total Disability

Claimant also challenges the Referee's conclusion that claimant was not permanently and totally disabled. In particular, claimant asserts that she is unable to regularly perform gainful and suitable employment based on a combination of her physical and emotional disabilities. See ORS 656.206(1)(a). We adopt and affirm that portion of the Referee's order discussing this issue and provide the following supplementation.

Claimant in part relies on the opinion of Dr. Baldwin, claimant's former orthopedic surgeon, that claimant's "significant preexisting psychological problems," in combination with her knee injury, rendered claimant totally and permanently disabled. (Exs. 77, 78). We find his opinion unpersuasive. First, Dr. Baldwin has not examined or treated claimant since 1984.

Furthermore, Dr. Baldwin's opinion is contradicted by that of Dr. Berselli, who has treated claimant since 1984. According to Dr. Berselli, claimant was capable of working in the absence of prolonged sitting and standing; in particular, he indicated that claimant could sit, stand and walk up to one hour at a time and frequently lift and carry up to 20 pounds. (Exs. 72, 79, 85). In May 1992, Dr. Berselli approved work for claimant as a teacher's aide, parking lot attendant, light assembly, playland clerk, and audio visual clerk. (Exs. 89-2, 98).

Thus, in view of Dr. Berselli's more recent and substantial contact with claimant, we find his opinion more reliable than that of Dr. Baldwin. See Weiland v. SAIF, 64 Or App 810 (1983).

Claimant also relies on a report by Dr. Colistro, claimant's former treating psychologist, that, in view of claimant's inability to successfully return to work, he could "accept and support the premise that when [claimant's] physical and psychologic problems are factored together they render her unemployable." (Ex. 97). We also are unpersuaded by this report. See Weiland v. SAIF, supra. First, all of Dr. Colistro's prior reports provided only that claimant's diagnosed mental disorder of Psychological Factors Affecting Physical Condition was "moderately disabling." (Exs. 31-4, 68, 93).

Furthermore, there was evidence that Dr. Colistro was of the opinion that claimant's greatest impairment was due to preexisting character traits. For instance, in a July 1992 "check-the-box" report drafted by the employer's attorney, Dr. Colistro agreed that claimant was "psychologically capable of engaging in gainful employment, and any self-perceived psychological barrier to her employability is a result of her preexisting underlying personality traits that have not been caused or permanently effected [sic] by the results of this knee injury." (Ex. 94-3). In the same report relied upon by claimant, Dr. Colistro stated that claimant suffered "from substantial preexisting characterologic disturbance which leaves her poorly disposed to cope with chronic pain." (Ex. 97). Based on such evidence, we find support for interpreting Dr. Colistro's statement that claimant was totally disabled due to preexisting character traits rather than her compensable knee injury and psychological condition.

Disability from a preexisting condition, even though not compensable, is considered in determining permanent total disability. Elder v. Rosboro Lumber Co., 106 Or App 16, 19 (1991). However, a post-injury increase in disability from such condition is not considered. Id. In view of the lack of evidence that claimant's character traits resulted in any disability before her injury and did not combine with her injury, we find that disability resulting from her character traits cannot be considered.

Finally, Dr. Colistro's opinion was not supported by Dr. Maletzky, psychiatrist, who examined claimant at the request of her attorney. He found that claimant continued to experience "moderate to severe anxiety and depression" due to her injury and resulting pain, (Ex. 86-2), and that it was disabling in the "mild to moderate" range, with an inability to tolerate a "highly stressful job setting." (Exs. 88, 91, 95).

Finally, claimant relies on the report from Andy Huckfeldt, vocational rehabilitation counselor, who evaluated claimant at her attorney's request. He found that claimant's work restrictions, combined with "the effects of chronic pain and psychological impairment," rendered her "nonfeasible in the labor market." (Ex. 90-7). As explained by Linda Hill, vocational rehabilitation counselor who rendered an opinion at the employer's request, Mr. Huckfeldt's report did not include education claimant received in 1983 and 1984 nor sufficiently consider claimant's potential employment as a teacher's aide. (Ex. 98-16, 98-17). We find that such evidence undermines the reliability of Mr. Huckfeldt's report. See Somers v. SAIF, 77 Or App 259 (1986). Furthermore, we find that Ms. Hill's opinion that claimant was likely employable in the light category and certainly in the sedentary category, (Ex. 98-23), is more consistent with the record.

Consequently, based on the foregoing analysis as well as the Referee's order concluding that claimant failed to make reasonable efforts find work, we conclude that claimant failed to prove that she is permanently and totally disabled. See ORS 656.206(1)(a).

Extent of Permanent Disability

We adopt and affirm this portion of the Referee's order.

ORDER

The Referee's order dated October 7, 1993, as corrected October 13, 1993, is affirmed.

August 16, 1994 Cite as 46 Van Natta 1644 (1994)

In the Matter of the Compensation of
DAVID RIDER, JR., Claimant
WCB Case Nos. 93-05739 & 93-02088
ORDER ON REVIEW
McGill & Kapranos, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

The self-insured employer requests review of Referee Thye's order that: (1) set aside its denials of claimant's claim for his left shoulder injuries; (2) awarded a penalty for the employer's allegedly unreasonable failure to pay interim compensation; (3) awarded a penalty for the employer's allegedly untimely denial; and (4) awarded a penalty for the employer's allegedly unreasonable failure to provide discovery. The employer also objects to claimant's submission of a "Respondent's Reply Brief" on review. On review, the issues are motion to strike, compensability and penalties and attorney fees.

The Board adopts and affirms the order of the Referee, with the following supplementation.

On review, the employer argues that there is no provision in the Board's rule which permits claimant to submit a "Respondent's Reply Brief." We agree that the Board's rule authorizes the filing of: an appellant's brief, a respondent's brief, a cross-appellant's brief, a cross-respondent's brief, an appellant's reply brief, and a cross-reply brief. There is no provision for a respondent to file a reply brief. OAR 438-11-020(2); Jerome D. McIntyre, 46 Van Natta 301 (1994). Accordingly, the employer's motion to strike claimant's reply brief is granted, and we do not consider that brief in our review.

Claimant is entitled to an assessed attorney fee for successfully defending against the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is $750, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues and the value of the interest involved. We note that no attorney fee is available for that portion of claimant's brief devoted to the penalty and attorney fee issues. Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated November 10, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750, to be paid by the self-insured employer.

In the Matter of the Compensation of
GREG V. TOMLINSON, Claimant
WCB Case No. 93-08814
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Referee Peterson's order that set aside its partial denial of claimant's total knee arthroplasty [replacement] surgery for an accepted left knee claim. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction and supplementation.

Claimant slipped and "wrenched," rather than "fell on," his left knee on March 2, 1993, sustaining internal derangement and a condylar flap tear. On May 3, 1993, Dr. Treible, claimant's treating surgeon, repaired the tear.

While on crutches and working at home, on May 26, 1993, claimant tripped, dislodging tissue healing from the May 1993 surgery. Claimant's pain continued unabated. On July 29, 1993, Dr. Treible performed total knee replacement surgery.

On June 3, 1993, the insurer accepted claimant's left knee injury claim for internal derangement with condylar flap tear. On July 23, 1993, the insurer partially denied claimant's left knee replacement surgery as "due to your pre-existing degenerative changes and not your industrial injury of 03/02/93."

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's accepted March 1993 industrial injury is the major contributing cause of his need for left knee replacement surgery, the Referee set aside the insurer's denial of claimant's medical services claim. On review, the insurer argues that claimant's preexisting degenerative arthritis, rather than the compensable injury, is the major contributing cause of claimant's need for knee replacement surgery.

We adopt and affirm the Referee's reasoning and conclusion that claimant's need for knee replacement surgery was caused in major part by the compensable injury.[1] Moreover, even if we

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[1] On review, the insurer argues that the Referee erred in relying on the opinion of treating physician Treible, because Dr. Treible has an incorrect understanding of the legal meaning of "major contributing cause." The insurer confuses the roles of the "expert" medical witness and the "trier of fact." The "expert" provides a medical explanation. The "trier of fact" reaches a legal conclusion based on the expert's explanation. In the instant case, it is our responsibility, utilizing the medical evidence, to determine if the requisite causation standard has been satisfied. On this record, we conclude, as did the Referee, that Dr. Treible's explanation demonstrates that claimant's compensable injury is the major contributing cause of his need for knee arthroplasty surgery.

were to find that claimant's compensable injury is only a material contributing cause of his need for knee replacement surgery, we would nonetheless find claimant's medical services claim compensable.

In Beck v. James River Corp., 124 Or App 484 (1993), citing Roseburg Forest Products v. Ferguson, 117 Or App 601, rev den 316 Or 528 (1993), the Court of Appeals determined that medical services for conditions resulting from a compensable injury are compensable if the need for treatment bears a material relationship to the compensable condition. Id. at 487. The court explained that ORS 656.005(7)(a), which defines a compensable injury, applies to initial determinations of compensability of a condition, i.e., to claims for new injuries or conditions different from an already accepted claim. The statute does not apply to a claim for continued medical treatment of a compensable condition under ORS 656.245(1). 124 Or App at 487.

Instead, such medical services are compensable even though claimant's treatment may also be partially attributed to a noncompensable injury or condition. See Donald E. Beck, on rem 46 Van Natta 1259, 1260 (1994) (A worker's need for treatment is compensable even if it is attributable to both a noncompensable injury and a compensable injury); Lucky L. Gay, 46 Van Natta 1252 (1994) (A worker's need for treatment is compensable where an intervening, noncompensable incident was the major contributing cause of the need to treat a compensable condition). Thus, in the instant case, claimant's medical services claim is compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245(1).

Here, the medical evidence establishes that claimant has a compensable left knee injury as well as noncompensable left knee degenerative arthritis. Claimant seeks no compensation for the left knee degenerative arthritis. Therefore, as in Beck, the issue is whether claimant's medical treatment is materially related to the compensable condition. Based on Dr. Treible's uncontradicted medical opinion, we find that it is.

Dr. Treible explained that "the medial femoral condylar defect was the direct precipitant causing the rapid deterioration in [claimant's degenerative] knee, causing him to have a total knee arthroplasty[.]" Dr. Peterson, who examined claimant at the request of the insurer, acknowledged that claimant's compensable injury was "significant." He did not offer an opinion as to whether claimant's need for treatment bears a material relationship to the compensable condition, instead opining only that claimant's preexisting degenerative arthritis is the major contributing cause of his need for knee replacement surgery.

Inasmuch as Dr. Treible attributes claimant's need for left knee replacement surgery to both claimant's noncompensable degenerative arthritis and the 1993 compensable injury, we find that such an opinion establishes that claimant's 1993 left knee injury is at least a material contributing cause of the need for knee replacement surgery. ORS 656.245(1); Beck v. James River Corp., supra. Thus, we affirm the Referee's decision setting aside the insurer's denial of claimant's left knee medical treatment claim.

Claimant is entitled to an assessed attorney fee for defending on the medical services issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the medical services issue is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 2, 1994 is affirmed. Claimant's attorney is awarded $1,200 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
ROBERT W. GETSINGER, Claimant
WCB Case No. 93-08517
ORDER ON RECONSIDERATION
Thomas Castle (Saif), Defense Attorney

On July 18, 1994, we issued our Order on Review which: (1) declined to remand the case to the Referee for the admission of further evidence; and (2) affirmed the Referee's order which upheld the SAIF Corporation's denial of claimant's low back injury claim. We have now received a letter from claimant, pro se, requesting "an appeals hearing."

We interpret claimant's letter as a request for reconsideration. Inasmuch as the next level of appeal is the Court of Appeals, yet claimant's letter has been directed to the Board, we construe claimant's letter as a reconsideration request, and we proceed to reconsider our prior order.

After reviewing the record and our Order on Review, we continue to reach the same conclusion on the issues of remand and compensability. In other words, we decline to remand the matter as we find that the evidence submitted by claimant was obtainable with due diligence at the time of hearing. In addition, for the reasons stated in our Order on Review, we continue to affirm the Referee's order which found that claimant had not proven a compensable low back injury.

Accordingly, claimant's request for reconsideration is granted and we withdraw our prior order. As supplemented herein, we republish our July 18, 1994 order in its entirety. The parties' rights of appeal shall run from the date of this order. In other words, if claimant is dissatisfied with our order, he should file his appeal with the Court of Appeals within 30 days from the date of this order, as explained in our appeal paragraph which is set forth below.

Finally, as it does not appear that counsel for SAIF has been provided with a copy of claimant's August 14, 1994 letter, a copy of that letter in enclosed with our order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSE R. CHAIDEZ, Claimant
WCB Case No. 93-02790
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of claimant's low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following modification and supplementation.

Chiropractor Towne first saw claimant on December 8, 1992, not December 14.

Claimant is a Hispanic man whose primary language is Spanish. Claimant is a credible witness.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, based on the inconsistencies in the evidence, claimant had failed to establish legal causation. We disagree.

Before we proceed, we note that it is unclear whether the parties are litigating this matter as an injury claim or as an occupational disease claim.[1] If it is the former, the material contributing cause standard applies. See ORS 656.005(7)(a). If it is the latter, the major contributing cause standard applies. See ORS 656.802(2). We need not decide which standard applies, because we conclude that claimant has established that his low back condition was caused, in major part, by his work activities.

Claimant's employment required him to lift 40 to 45 pound boxes of fruit onto pallets continuously each work day. He first experienced low back pain on approximately November 30, 1992. Claimant did not work between December 1 and December 7, because of lack of available work. At hearing, claimant did not recall anything about his back condition during his time off. (Tr. 12).

Claimant worked eight hours on December 7. He complained to a co-worker of back pain that day. The next day, claimant's back pain had become so severe, he could not work. That day, he began treating with Dr. Towne, chiropractor. Claimant was accompanied by a friend, who interpreted for him. Claimant told Dr. Towne that he had a history of gradually increasing back pain that began at work. (See Ex. 11-12). Dr. Towne concluded that claimant had acute traumatic sacroiliac sprain. (Ex. 3).

Claimant subsequently saw Dr. Saviers, physical medicine and rehabilitation specialist, and a physical therapist. Dr. Saviers reported the following:

> "[Claimant] states that he was loading and unloading boxes of fruit from pallets. The boxes weighed from 40 to 45 lbs. and he had to stack them from 7' level down to floor level. He states that over several days he had progressively increasing pain in the lower lumbar spine, left sacroiliac joint region. On the final day, the pain became so severe he could not straighten up and the next day he had difficulty getting out of bed. He estimated the date was 11/30/92. He stated that he had waited a week to file a work claim because he was hoping the back pain would just go away." (Ex. 5-1).

The physical therapist recorded that claimant's symptoms began on November 30, 1992, while he was lifting a crate of apples at work. (Ex. 6-1). His pain gradually increased over the following week, to the point that he could not work. (Id.)

When claimant filled out his "801" form on December 10, 1992, he indicated that he had injured his back in the past in an automobile accident. (Ex. 2). At hearing, he testified that his back was x-rayed following the accident, but had not been injured. (Tr. 6).

Subsequently, in a concurrence letter from claimant's counsel, Towne agreed that he had received a history from claimant and his friend that claimant had injured his back lifting boxes off a pallet at work. (Ex. 10-1). Based on that history, Towne agreed that it was probable that the major cause of claimant's sacroiliac strain was his work activities. (Id.) Towne adhered to that opinion after being apprised of claimant's automobile accident, because the accident had occurred in mid-1992 and did not involve continuing symptoms. (Id.)

At Dr. Towne's deposition, claimant's counsel inquired:

> "Q. Doctor, if, in fact [claimant] was loading and unloading boxes of fruit and the boxes weigh 40 to 45 pounds, and he was involved in stacking them from the floor to seven feet in the air, and that he reported over several days his back got progressively worse and ultimately became -- on the final day became so severe he couldn't straighten out, would that be consistent with your opinion that it was a work related injury?" (Ex. 11-16).

Dr. Townsend responded, "That would fit it perfectly." (Id.) The insurer did not offer any contrary medical opinion.

At hearing, claimant testified that he thought that he had been injured on December 1 and that his condition markedly worsened after he returned to work on December 7. (See Tr. 6, 9-11).

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[1] The insurer denied claimant's claim for low back spasms. (Ex. 9-1). The Referee characterized the issue as the compensability of an injury that occurred on November 30, 1992, while, in his appellant's brief, claimant states that the issue is whether his work was the major contributing cause of his injury. (Claimant's Appellant's Brief at 5).

On this record, we find Dr. Towne's opinions sufficient to meet claimant's burden of proof. Although Towne did not have a detailed history initially, once he was apprised of the facts surrounding claimant's injury, he persuasively concluded that claimant's work was, in fact, the major contributing cause of his low back injury. Furthermore, Towne convincingly ruled out claimant's automobile accident as a cause of claimant's sacroiliac strain. Towne's analysis is supported by claimant's credible testimony that, although his back was x-rayed after the accident, it had not been injured.

The insurer argues that several inconsistencies in the record undercut claimant's compensability arguments. Before we address those arguments, we note that we have found claimant to be a credible witness. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Therefore, to the extent that the insurer's arguments indirectly seek to impeach claimant's credibility, we reject them outright. We turn to the insurer's arguments.

First, the insurer argues that it is unclear when and how claimant's back condition arose. We reject that argument. The record contains some inconsistencies regarding when claimant's back pain began. Nevertheless, we conclude that, in light of the facts that discrepancies regarding claimant's onset of symptoms are so minor and that his primary language is not English, the record is sufficiently clear to establish that his back began hurting on either November 30 or December 1, 1992, and increased on December 7, 1992, when he returned to work after several days off. Furthermore, the record establishes that claimant's work involved repetitive, back-intensive work. On this record, we conclude that claimant has established when and how his back condition arose.[2]

The insurer next argues that the record contains insufficient evidence regarding claimant's physical condition on December 7, the day on which claimant asserted that his back condition worsened. Claimant testified that he had obvious physical problems that day and that he had told a co-worker about his back the same day. (See Tr. 13-14). Although claimant offered no witness to corroborate that testimony, because we have found claimant to be a credible witness and because the insurer presented no persuasive evidence that claimant did not manifest back symptoms that day, we reject the insurer's argument.

Lastly, the insurer argues that claimant has failed to meet his burden of proof on the ground that claimant's recollection regarding the events surrounding the onset of his back symptoms was inconsistent. At hearing, claimant described with relative precision details about his back condition on November 30 or December 1, and on December 7 and 8, but that he had no recall about his back condition from December 2 to 6. We conclude that, because claimant was not at work on the days in question (and hence, likely was not repetitively stressing his back as he did at work), his lack of recall regarding his back condition during the first week of December 1992 is understandable.

In sum, we conclude that claimant has established that his work activities were the major contributing cause of his low back condition. Accordingly, we reverse the Referee's decision upholding the insurer's denial of that condition.

Claimant is entitled to an assessed attorney fee for services at hearing and on Board review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,500. In reaching this decision, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated November 2, 1993 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded $3,500, to be paid by the insurer.

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[2] The insurer argues that Dr. Saviers reported that claimant had insidious, progressive pain at work that peaked on November 30, 1992. (Ex. 5-1). Based on our review of Dr. Saviers' report, we conclude that it is unclear whether his reference to November 30 concerned the onset or peak of claimant's back pain. In any event, we are not persuaded that Saviers' report is sufficient to impeach the other evidence regarding the onset of claimant's back symptoms.

In the Matter of the Compensation of
KEITH L. FALLS, Claimant
WCB Case No. 93-08205
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Spangler's order that: (1) set aside an Order on Reconsideration that affirmed a Determination Order reclassifying claimant's thoracic strain injury claim as disabling; and (2) directed that claimant's claim be classified as non-disabling. On review, the issues are the preclusive effect of a stipulation on a thoracic strain injury claim and, alternatively, reclassification. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, by entering into a stipulation in which the self-insured employer agreed to accept claimant's back claim as non-disabling, claimant had waived the right to litigate the classification issue thereafter. We adopt and affirm the Referee's conclusions,[1] and offer the following additional analysis regarding the preclusive effect of the parties' stipulation regarding claimant's thoracic strain injury claim.

In Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), the court reversed a Board order that had held that a claimant's wrist nerve condition was not barred by a prior stipulation unless the claimant "intended to waive that right when she signed the stipulation." The employer had yet to accept or deny that condition. Reasoning that the statutory scheme does not permit a hearing on the compensability of a claim before acceptance or denial, we concluded that the compensability issue was not ripe and, therefore, could not be waived.

The court rejected our analysis. Instead, relying on Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993) and the fact that the stipulation purported to resolve all issues that were raised or raisable before the date of the settlement, the court explained that the "correct inquiry is whether [the] claimant's condition and its compensability could have been negotiated before approval of the settlement." Stoddard, supra, 126 Or App at 73. The court then reasoned that, because the claimant's nerve condition had been diagnosed before the parties entered into the stipulation, that condition was an issue that could have been raised before that date. Id. Therefore, the court concluded that the claimant's wrist condition claim was barred by the stipulation.

We reach the same conclusion here. Claimant injured his back in May 1992. The employer initially accepted a non-disabling thoracic strain, but then, in September 1992, issued a "back-up" denial of that condition. In November 1992, claimant requested a hearing regarding compensability. In February 1993, claimant's counsel wrote to the employer's claim's administrator requesting that the claim be reported to the Director for reclassification as disabling.

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[1] Claimant argues that, because the classification issue was not ripe until the employer accepted the back claim on April 15, 1993, Referee Johnson did not have jurisdiction to decide a classification dispute and, therefore, with respect to the classification issue, the stipulation did not bind claimant. We disagree. By signing the stipulation, Referee Johnson merely approved the parties' agreement that claimant's condition was non-disabling; he did not decide a classification dispute. Moreover, because we agree with the Referee that claimant waived his right to challenge the classification of his claim by entering into the stipulation, we conclude that claimant necessarily relinquished his right to raise any procedural or substantive arguments with respect to the classification of his claim. Accordingly, we reject his ripeness argument.

Relying on Donald R. Dodgin, 45 Van Natta 1642 (1993), claimant also argues that, because he sought reclassification of his claim within one year of his injury, once the employer accepted his claim pursuant to the stipulation, he became entitled to exhaust his administrative remedies, i.e., to request reclassification. We disagree. In Dodgin, the parties had entered into a stipulation in which the carrier agreed to accept the claimant's wrist injury claim; however, the stipulation said nothing about the classification of the claim. Because the stipulation in this case did address the classification issue, we find Dodgin distinguishable.

On April 15, 1993, the parties entered into a stipulation wherein the employer agreed to rescind its September 1992 denial and to "accept claimant's workers' compensation claim for a thoracic claim as non-disabling." (Ex. 38-2; emphasis added). The stipulation also stated:

> "Claimant further agrees that he has no other claims for workers' compensation benefits, whether filed or not, not otherwise resolved by this stipulation and that this stipulation resolves all issues currently raised or raisable." (Id.; emphasis added).

Referee T. Lavere Johnson approved the stipulation. On April 19, 1993, the employer accepted claimant's condition as non-disabling by filing a "1502" form with the Department, and copying the form to claimant. (Ex. 39).[2]

In light of the fact that the stipulation resolves all issues then raised or raisable, the correct inquiry is whether the classification of claimant's claim could have been negotiated before approval of the stipulation. See Stoddard, supra, 126 Or App at 73. Although the stipulation arose from claimant's request for hearing regarding compensability, we conclude that, in view of claimant's February 1993 request for reclassification, which was directed to the employer, the classification question was an issue that could have been negotiated before approval of the stipulation. In other words, one of the issues that was "raisable" was whether the claim should be accepted as disabling or non-disabling. Under the circumstances, we conclude that the stipulation precludes claimant from further litigating the classification issue.[3]

Alternatively, we conclude that issue preclusion bars claimant from relitigating the classification issue.[4] Under the doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusion in a subsequent action between the parties, whether on the same or a different claim. Drews v. EBI Companies, 310 Or 134, 139-40 (1990); North Clackamas School Dist. v. White, 305 Or 48, 53, mod 305 Or 468 (1988). Issues resolved by a stipulation and settlement are considered to be actually litigated and determined by a valid and final judgment for issue preclusion purposes. Eileen A. Edge, 45 Van Natta 2051 (1993); see International Paper Co. v. Pearson, 106 Or App 121 (1991).

On this record, we conclude that one of the issues resolved by the parties' April 1993 stipulation was the classification of claimant's back injury claim. The stipulation plainly states that the employer agreed to accept the condition as non-disabling. Accordingly, we hold that the stipulation establishes as a matter of law that claimant's condition was non-disabling. In other words, the classification of claimant's back condition was litigated and determined by a valid and final judgment when the parties entered into the stipulation that the employer would accept the claim as non-disabling. See International Paper Co. v. Pearson, supra; Eileen A. Edge, supra.

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[2] Thereafter, the Evaluation Section issued a Determination Order reclassifying claimant's back claim as disabling. An Order on Reconsideration affirmed the Determination Order. This case arose when the employer appealed the Order on Reconsideration.

[3] Claimant argues that, because it was his understanding that claim classification was not essential to the stipulation regarding compensability, and because the stipulation fails to mention claimant's February 1993 request for reclassification, he did not waive his right to contest the classification of his claim. Neither argument is well-taken. First, because it is unambiguous, we discern claimant's "understanding" from the face of the stipulation, without resort to any undisclosed assertions regarding his intent. See Timberline Equip. v. St. Paul Fire and Mar. Ins., 281 Or 639, 643 (1978). Second, we agree with the employer that, because claimant made his February 1993 request for reclassification while the claim was in denied status, the request was a nullity. Therefore, the fact that the stipulation failed to mention the request is of no import.

[4] The employer argues that claimant is barred, by claim preclusion, from relitigating the classification issue. Because the classification question appears to have been ancillary to the primary issue resolved by the stipulation, i.e., compensability, we conclude that issue, and not claim, preclusion is the appropriate doctrine to apply to this case.

Furthermore, because the employer specifically agreed to the accept a non-disabling claim, it follows that the determination of the classification issue was essential to the final decision. See Drews v. EBI Companies, supra; North Clackamas School Dist. v. White, supra. For these reasons, we conclude that claimant is barred by issue preclusion from relitigating the classification issue.

ORDER

The Referee's order dated October 27, 1993 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that the parties' stipulation precludes claimant from further litigating the classification of his thoracic strain injury claim. Accordingly, I dissent.

Up to one year following the date of injury, a claimant may request reclassification of an accepted claim. See ORS 656.262(6)(c); see also ORS 656.277. On receipt of a request for reclassification, the Department shall determine whether a claim is disabling or non-disabling. ORS 656.268(11).

In light of this reclassification procedure, I would hold that, in the absence of language that clearly expresses the parties' intent that a claim to be, and always remain, classified as either disabling or non-disabling, a stipulation to a particular classification represents nothing more than the parties' beliefs regarding the claim's proper classification at the time the stipulation is negotiated. In other words, without language to the effect that the claimant has waived his statutory right to request reclassification of the claim, I would give no preclusive effect to a stipulation that purports to accept a claim as non-disabling.

Here, the parties' stipulation does not clearly manifest the parties' intention that this claim be, and always remain, classified as non-disabling. Furthermore, nothing in the stipulation reveals claimant's intent to waive his statutory right to request reclassification of his claim. Therefore, I would conclude that, under these circumstances, claimant is not precluded from litigating the classification issue in this proceeding.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
MARK OSTERMILLER, Claimant
WCB Case No. 93-04010
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

On August 15, 1994, we denied the self-insured employer's request that we abate our July 21, 1994 Order on Review because we had not received a request for reconsideration. We have now received the employer's motion for reconsideration. Contending that we erroneously relied on the opinion offered by claimant's attending physician (rather than opinions from the physicians who examined claimant at the employer's request), the employer seeks abatement of our orders for reconsideration by the Board en banc.

In order to further consider the employer's arguments, we withdraw our prior orders. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CAROLYN BROWN, Claimant
WCB Case No. 93-02462
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Gunn.

Claimant requests review of that portion of Referee Myzak's order that declined to award an assessed attorney fee. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the SAIF Corporation had "de facto" denied certain medical services and set aside the "de facto" denial, finding the medical treatment compensable. However, based on SAIF v. Allen, 124 Or App 183 (1993), the Referee declined to award claimant's attorney an assessed fee for prevailing against the "de facto" denial. On review, claimant asserts that he is entitled to either an assessed fee pursuant to ORS 656.386(1) or 656.382(1).

Following the Referee's order, we issued the order in Gwen A. Jackson, 46 Van Natta 357, on recon 46 Van Natta 822, 825 (1994), holding that, because it was a plurality decision, SAIF v. Allen, supra, had no binding precedential value. Furthermore, based on Shoulders v. SAIF, 300 Or 606 (1986), and Short v. SAIF, 305 Or 541 (1988), we held that an assessed fee under ORS 656.386(1) is warranted when the claimant finally prevails over an "order or decision denying a claim for compensation", including medical services. 46 Van Natta at 825-26.

Before hearing, SAIF had paid for medical treatment rendered by claimant's treating physician, but not for services by consulting physician Dr. Mehr. At hearing, claimant's attorney asserted that Dr. Mehr's treatment constituted compensable diagnostic services. (Tr. 2). SAIF's counsel agreed that Dr. Mehr's bills were "at issue" and that the "main issue" was whether Dr. Mehr's treatment was causally related to the occupational injury. (Id. at 2-4).

Based on this colloquy, we find that SAIF rendered a decision denying the claim for Dr. Mehr's medical services on the basis that such treatment was not causally related to the compensable injury. Inasmuch as the Referee found that Dr. Mehr's treatment was compensable diagnostic services, and since such a conclusion is not challenged on review, we find that claimant prevailed at hearing over the decision denying the claim for compensation. Consequently, claimant's attorney is entitled to an assessed fee under ORS 656.386(1). Shoulders v. SAIF, supra; Short v. SAIF, supra; Gwen A. Jackson, supra.

We find no entitlement to an additional assessed fee pursuant to ORS 656.382(1). First, there is some merit to SAIF's argument that, by failing to allege unreasonable conduct, claimant should be prevented from raising the issue on review. Alternatively, assuming that claimant properly raised entitlement to a fee under ORS 656.382(1), we find no unreasonable resistance to the payment of compensation in view of Dr. Mehr's correspondence indicating that SAIF was not responsible for the medical bills. (Ex. 14).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney services at hearing is $500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the medical service claim issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to a fee for services on review regarding the attorney fee issue. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated December 9, 1993 is reversed. Claimant's attorney is awarded an assessed fee of $500 for services at hearing, payable by SAIF.

In the Matter of the Compensation of
MARTA I. GOMEZ, Claimant
WCB Case No. 93-01349
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Hoguet's order that declined to award claimant unscheduled permanent disability for chronic conditions limiting repetitive use of her neck, upper back and left shoulder. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the Referee's order, with the following supplementation.

The only evidence regarding claimant's purported neck, upper back and left shoulder chronic conditions is a "check-the-box" report from Dr. Lee, claimant's treating physician, indicating his agreement that claimant has those conditions. (Ex. 32). The Referee concluded that the report was unpersuasive and, hence, that claimant had failed to establish her entitlement to a chronic condition permanent disability award.

Claimant argues that the Referee's refusal to rely on Dr. Lee's "check-the-box" report violates OAR 438-07-005(4), which provides:

> "To avoid unnecessary cost and delay, the Board encourages the use of written interrogatories or deposition to secure medical * * * expert testimony."

Assuming arguendo, as claimant asserts, that a "check-the-box" report is a written interrogatory for purposes of OAR 438-07-005(4), we nevertheless conclude that the Referee's decision not to rely on Lee's "check-the-box" report did not violate that rule.

OAR 438-07-005(4) expresses this Board's preference for the use of written interrogatories and/or depositions as a means of avoiding unnecessary costs and delays in the procurement of medical expert testimony. It does not relieve the Board of its obligation to evaluate the sufficiency and persuasiveness of medical evidence submitted as interrogatories or depositions. Therefore, regardless of the form in which medical expert testimony is submitted, we will continue to give the most weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Conversely, we will give the least weight to conclusory, poorly analyzed opinions, such as unexplained, conclusory "check-the-box" reports. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical report); see also William F. Gilmore, 46 Van Natta 999, 1000 (1994) (unexplained, conclusory "check-the-box" report held insufficient to meet the claimant's burden of proof).

Whether referred to as a "check-the-box" report or a "concurrence", the persuasiveness of a medical expert's response depends on the explanation that corresponds to the expert's opinion. For very real and practical reasons (such as cost and time constraints), the explanation may have to be articulated or summarized by someone other than the doctor, or it may include citation to explanations and rationale already available elsewhere in the record, with the doctor then adopting that explanation. In the end, however, the persuasiveness of the expert's opinion still depends on the persuasiveness of the foundation on which the opinion is based. A preference for interrogatories does not relieve a party of the burden of providing a persuasive explanation for the interrogatory answer.

On this record, we agree with the Referee that Dr. Lee's unexplained "check-the-box" report indicating that claimant has chronic conditions limiting the repetitive use of her neck, upper back and left shoulder is unpersuasive. Accordingly, we affirm the Referee's decision declining to award claimant unscheduled permanent disability for those conditions.

ORDER

The Referee's order dated December 22, 1993 is affirmed.

In the Matter of the Compensation of
KENNETH R. PECK, Claimant
WCB Case No. 93-06055
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Thye's order that: (1) upheld the insurer's denial of his injury claim for a low back condition; (2) affirmed an Order on Reconsideration which awarded 35 percent (112 degrees) unscheduled permanent disability; and (3) declined to award penalties or attorney fees for the insurer's untimely acceptance of his cervical condition. On review, the issues are compensability, extent of permanent disability, penalties and attorney fees.

We adopt and affirm the Referee's order with the following supplementation.

There is no dispute that claimant's cervical condition is compensably related to claimant's June 10, 1992 injury. Nor do the parties disagree that the insurer waited approximately six months after having knowledge of that condition before issuing a formal acceptance on April 29, 1993. (Ex. 42).

At hearing, claimant sought an assessed attorney fee under ORS 656.382(1) for the insurer's failure to timely accepted claimant's cervical condition. Relying upon SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993), the Referee concluded that the carrier's late acceptance was not an unreasonable resistance to the payment of compensation because there was no unpaid compensation then due (i.e., the carrier could not unreasonably resist the payment of compensation that had been paid).

Claimant now requests an assessed attorney fee under ORS 656.386(1) based on the same grounds. Because claimant did not pursue the attorney fee issue at hearing under ORS 656.386(1), but rather sought a penalty-related fee under ORS 656.382(1), we are not inclined to consider that issue on Board review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Alternatively, to the extent that claimant argues that his attorney was instrumental in obtaining the insurer's formal acceptance of his cervical condition, we do not agree. The insurer accepted claimant's cervical condition on April 29, 1993, but claimant did not request a hearing until May 25, 1993. There is no evidence that the insurer neglected to compensate claimant for his cervical condition, or that the compensation was delayed.

Therefore, inasmuch as there is no evidence that claimant's counsel was involved in the insurer's decision to issue a formal acceptance of claimant's cervical condition, we cannot conclude that claimant's attorney was "instrumental in obtaining compensation for a claimant." ORS 656.386(1).

ORDER

The Referee's order dated October 19, 1993 is affirmed.

In the Matter of the Compensation of
DAVID A. PEPER, Claimant
WCB Case No. 93-02312
ORDER ON REVIEW
Dennis H. Henninger, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

The SAIF Corporation requests review of Referee Galton's order which set aside its denial of claimant's cervical condition claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the second paragraph of his findings of fact and his ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Based on claimant's testimony and on the opinion of Dr. Rosenbaum, claimant's treating physician, the Referee found that a work incident occurring on November 10, 1992 was at least a material contributing cause of claimant's disc protrusion. The Referee thus concluded that claimant established a compensable injury claim.

Although the Referee accepted claimant's testimony, he made no express credibility findings based upon claimant's demeanor. Although the Board generally defers to the Referee's determination of credibility when that finding is based on the Referee's opportunity to observe claimant's demeanor, we are in as good a position as the Referee to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

The Referee did not give detailed explanations for his decision that the discrepancies and inconsistencies in the record were insignificant to the question of causation and to an assessment of claimant's credibility. Even minor inconsistencies can be a sufficient basis to disagree with the Referee's credibility determination, particularly where factual inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. Angelo L. Radich, 45 Van Natta 45, 46 (1993); Ronald A. Pickett, 37 Van Natta 675, 680 (1985).

Claimant testified that while twisting and leaning over to pick up a welding stinger, he felt like he "pulled a muscle" in his upper back between the shoulder blades. He did not tell anyone immediately, but later he told Brian Trosin, his foreman, that he hurt and that it felt like he had a pulled muscle. (Tr. 13-14, 32). On Sunday, November 22, 1992, claimant awoke in severe pain. He could not straighten out his neck and he had numbness in his arm and fingers. (Tr. 15; Ex. 7). Claimant sought treatment on November 23, 1994 and underwent surgery on November 25, 1992 for a C6-7 disc herniation. Dr. Rosenbaum performed the surgery.

Brian Trosin testified that about a week before claimant's surgery, claimant came to him and told him that he had pain in the left side of his neck and arm, but that claimant did not know if he had hurt himself at work or elsewhere. (Tr. 43, 47).

Daniel LaVeine testified that claimant called him in the morning of November 24, 1992 and told him that he had been to the doctor. LaVeine asked claimant how he got injured, and claimant replied that he had no idea what brought it on. Claimant called LaVeine later that day and told him that he had a ruptured disc requiring surgery. LaVeine asked claimant if he remembered any specific incident at work that started it, and claimant replied that it had started hurting a couple of weeks ago and that it felt like a pulled muscle. (Tr. 60-62; Ex. 6A). Claimant did not describe any twisting incident to either Trosin or LaVeine.

Dr. Rosenbaum examined claimant on November 25, 1992 for complaints of left arm pain, pain in the left interscapular region, and numbness and paresthesia in the first three digits of the left hand. Dr. Rosenbaum obtained a history that several weeks ago without known injury claimant developed the onset of left intrascapular and arm pain. Claimant then awoke in the morning in severe pain and weakness in the left arm. Dr. Rosenbaum diagnosed left C6-7 disk herniation with radiculopathy and weakness. (Ex. 7).

In December 1992, the employer informed claimant that he needed to pay for his private insurance in order to keep it in force. (Tr. 29). In January 1993, claimant brought in his check to pay for his insurance, but learned that that his private insurance could not be reinstated. He subsequently returned to the employer to request an 801 Form. (Tr. 30-31, 50-51, 56). Claimant signed an 801 Form on January 25, 1993, claiming that he had twisted and leaned over to pick up material, that it felt like he had pulled a muscle, and that after two weeks of pain, he went to the doctor, which revealed a ruptured disc. He gave the date of injury as November 10, 1992. (Ex. 13).

Claimant testified that, prior to his seeking treatment, his employer had just started constructing a large conveyor and had been working nine-hour days and occasional overtime. (Tr.11-12). Andrew LaVeine, Vice President of sales and marketing, testified that, around November 10, 1992, the company began a job for a long conveyor. After the preliminary processing stage, claimant would have begun working on the conveyor around November 16th or 17th. (Tr. 93-95). Mr. Trosin believed that at that time they had been working a regular schedule. (Tr. 43).

There is no dispute that claimant sustained a C6-7 disc herniation. The dispute is whether claimant's condition is work related. Based on the contemporaneous medical evidence and on the testimony of Brian Trosin and Daniel LaVeine, we are not persuaded that claimant sustained an injury at work. Even if a twisting incident occurred, claimant did not relate that incident to his "pulled muscle" complaints until two months after the alleged incident, by which time he had been terminated and believed that he had no private insurance coverage. The many inconsistencies between claimant's testimony and the other witnesses, and between claimant's version of the alleged injury and the events that followed, lead us to conclude that claimant is not credible.

The medical evidence also does not support compensability. Dr. Berquist, who had obtained a history of the twisting and leaning incident, did not relate claimant's disc herniation to that incident. Dr. Berquist opined that the major contributing cause of claimant's cervical disc herniation was degenerative cervical disc disease. Dr. Berquist explained that a person may herniate a disc in his sleep or with trivial activity such as coughing or sneezing. He further stated that there is no good evidence in the medical literature that disc herniations are associated with the type of occupation a person is engaged in. (Ex. 19).

Dr. Rosenbaum did not agree with Dr. Berquist's assessment of the cause of the cervical disc herniation. Dr. Rosenbaum opined that claimant's disc herniation may have occurred as a result of his work activities as a welder. Dr. Rosenbaum explained that a soft disk protrusion frequently does not result in instantaneous symptoms and may have a delayed course of several days. A disc herniation occurring spontaneously during sleep is less likely than a daytime herniation with its attendant stress and strains to the cervical spine. However, some form of traumatic event, either superimposed trauma or minor trauma, is necessary to cause a disc herniation. Dr. Rosenbaum concluded that without the history of direct trauma following an industrial event, he could not say with certainty that claimant's cervical disc herniation was work related, but it was a possibility. (Exs. 20, 21).

We generally give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are a number of reasons not to defer to Dr. Rosenbaum's opinion.

Dr. Rosenbaum saw claimant twice following the November 25, 1992 surgery, the last time on December 12, 1992. Despite Dr. Rosenbaum's vantage point as claimant's surgeon, he is in no better position than Dr. Berquist to evaluate the etiology of claimant's herniated disc. (Since the pivotal issue for resolution is whether claimant's medical and work history was accurately represented to the medical experts. See Miller v. Granite Constr. Co., 28 Or App 473 (1977)). Thus, this case involves expert analysis rather than expert external observations and, therefore, we do not defer to the opinion of claimant's treating physician. Allie v. SAIF, 79 Or App 284 (1986).

Dr. Rosenbaum had an inaccurate history of claimant's work activities and no history of the alleged twisting incident. Claimant testified that he told Dr. Rosenbaum the type of work he was doing. However, Dr. Rosenbaum posited that claimant may have suffered the disc herniation when he was performing "welding which requires significant physical exertion." (Ex. 20). However, at the time of the alleged injury, claimant was not performing welding or any other work that requires "significant physical exertion." (Tr. 35; Ex. 19-2). Dr. Berquist had a history of an alleged twisting incident, but did not relate that incident to claimant's disc herniation. Finally, although medical certainty is not required,

the medical evidence must show more than a mere possibility. Gormley v. SAIF, 52 Or App 1055 (1981). We, thus, do not rely on Dr. Rosenbaum's opinion. Claimant has failed to carry his burden of proving compensability.

ORDER

The Referee's order dated December 14, 1993 is reversed. The SAIF Corporation's February 8, 1993 denial is reinstated and upheld. The Referee's assessed attorney fee award is also reversed.

Board Member Gunn dissenting.

The majority disregards the Referee's credibility findings, finds the claimant not credible, finds the treating doctor's opinion unpersuasive, and concludes, based on these findings, that claimant's claim is not compensable. Because I disagree with the majority's findings and conclusions, I respectfully dissent.

I find that claimant is credible. Claimant remembers an incident at work where he felt like he "pulled a muscle" between his shoulder blades. Claimant's version of the work incident is consistent from the outset. This is also the description of the injury that he gave his foreman, that he claimed on the 801 Form, and that he testified at hearing. Claimant's inability to initially recite a specific trauma event is also consistent with the history he provided to Dr. Rosenbaum, to his foreman, and to Daniel LaVeine. Thus, I conclude that claimant's testimony is not inconsistent, but rather credibly establishes that he sustained a work-related injury.

I also find that Dr. Rosenbaum accurately describes claimant's work as requiring significant physical exertion. The testimony establishes that claimant's work involved extensive physical labor. The employer manufactures heavy equipment for the timber and recycling industries. These vibrating conveyors are constructed of steel I beams. Claimant usually worked with angle modules which varied in weight from 50 to 150 pounds. The work is repetitive. This type of work activity is consistent with Dr. Rosenbaum's opinion that claimant's cervical disc herniation resulted from trauma occurring with work activities. Thus, I find Dr. Rosenbaum's opinion persuasive.

In sum, claimant has proven that he was injured on the job and that the injury caused the herniated cervical disc. Claimant has carried his burden of proof.

In the Matter of the Compensation of
VELMA D. SINOR, Claimant
WCB Case No. 93-06373
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

The self-insured employer requests review of Referee Menashe's order which set aside its denial of claimant's cervical condition. On review, the issue is compensability.

We adopt and affirm the Referee's order, with the following supplementation.

The Referee relied on the opinion of Dr. Frank, treating surgeon, to find claimant's herniated cervical disc compensably related to her accepted, nondisabling cervical strain. The employer contends that Dr. Frank's opinion is not persuasive because he had an inaccurate history that claimant had continuing neck symptoms, radicular symptoms, and headaches since her May 17, 1991 work injury.

Claimant testified that she began having headaches about a week or two after the injury, when she bent her head way over. (Tr. 28). She also said that she told the doctors about her symptoms, no matter how minor or infrequent they were. (Tr. 30). Claimant also testified that she had no improvement in her symptoms, but they rather got worse, when she treated with Dr. Riggs. (Tr. 31). Claimant's testimony, however, is inconsistent with the contemporaneous medical records.

Claimant initially treated with Dr. Johnson for her injury. On May 20, 1991, Dr. Johnson reported symptoms of spasm in the right rhomboid and decreased thoracic ranges of motion. He did not note any radicular complaints or headaches. (Exs. 2A, 38B pp. 7, 18-20, 24, 26-27, 38). The symptoms Dr. Johnson identified did not indicate a disk herniation; rather, he thought he was dealing with a soft tissue injury. (Ex. 38 pp. 22, 24). Dr. Johnson last treated claimant for the May 1991 injury on August 28, 1991. (Exs. 12AA; 38B-20).

Claimant began treating with Dr. Riggs on July 3, 1991. He obtained a history that at the time of injury, claimant felt immediate pain in the left trapezius and occasionally down the right arm; no weakness or numbness; and pain into right arm has resolved. Headaches were not noted. The neurological examination was normal. Dr. Riggs diagnosed neck/trapezius strain without evidence of radiculopathy. (Exs. 5, 6). Dr. Riggs' records did not indicate that there was a herniated disk. (Ex. 40-28). Dr. Riggs released claimant to regular work on July 3, 1991. (Ex. 8). On October 14, 1991, Dr. Riggs noted that claimant was doing pretty well. He found her neck strain resolved and declared her medically stationary with no residual deficits. (Ex. 12).

Claimant's witnesses testified that after the May 1991 injury, claimant's condition progressively worsened. Ms. Cox testified that she noticed a change in claimant's condition after claimant quit work in September 1992. (Tr. 60-62). Ms. Hanford testified that she noticed a dramatic change in claimant's condition around December 1992. (Tr. 66). Ms. Zurfleuh noticed a definite change in claimant's condition shortly before claimant quit work. (Tr. 74, 76). Their testimony is relatively consistent with claimant's return to treatment with Dr. Koznek. Dr. Koznek saw claimant on September 9, 1992 and reported that claimant's upper back and neck pain returned to the extent that claimant was unable to continue working. (Ex. 15).

Dr. Franks first saw claimant on February 26, 1993, on referral from Dr. Koznek. Dr. Franks causally related claimant's herniated disc to her compensable injury based on the absence of neck and upper extremity symptoms before the May 1991 injury, whereas she has had symptoms ever since the injury. Dr. Frank opined that the May 1991 injury caused a discal increase of pressure at C5-6 (thereby worsening the preexisting degenerative disc disease) that has become symptomatic. (Exs. 32, 35, 38, 39). Dr. Franks' opinion establishes that the May 1991 injury made the degenerative condition symptomatic, resulting in the need for surgery. ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

The opinion of Dr. Rosenbaum, neurosurgeon, is consistent with Dr. Franks' opinion. Dr. Rosenbaum opined that claimant had a chronic cervical strain as a result of the May 1991 injury. He further opined that the degenerative condition was the cause of the herniated disc. Dr. Rosenbaum, therefore, believed that claimant's symptoms from the injury had resolved. He, however, also opined that claimant's current symptoms were posterior cervical aching superimposed upon preexisting degenerative disc disease. We interpret Dr. Rosenbaum to state, and we conclude, that claimant's cervical strain injury made her degenerative disc disease symptomatic, and that her resultant condition is chronic cervical strain superimposed upon degenerative disc disease.

Thus, although we find inconsistencies in claimant's history and find that claimant's condition changed/worsened around September 1992, the medical evidence establishes that claimant's compensable cervical strain made her preexisting, asymptomatic degenerative disc disease symptomatic. None of the examining physicians, including Dr. Frank, dispute that claimant has preexisting cervical degenerative disc disease. The physicians also agree that claimant does not have objective evidence of radiculopathy. However, prior to the May 1991 injury, the degenerative condition was asymptomatic. After the injury, claimant's symptoms progressed. The opinions of Drs. Frank and Rosenbaum establish that the injury made the degenerative condition symptomatic, resulting in surgery. Claimant's resultant condition is compensable. U-Haul of Oregon v. Burtis, supra.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated November 3, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the self-insured employer.

Board Member Haynes dissenting.

Citing U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), the majority concludes that claimant's cervical herniated disc was compensably related to her accepted, nondisabling cervical strain. In reaching its conclusion, the majority construes the medical evidence as establishing that the compensable injury made claimant's degenerative cervical disc disease symptomatic, resulting in the need for surgery for the herniated disc. Because the majority's holding needlessly expands Burtis, I dissent.

In Burtis, the employer accepted the claimant's claim for chronic cervical strain as an injury. The Board held that the claimant's compensable injury was the major contributing cause of his disability and need for treatment, including surgery, and, therefore, he proved compensability under ORS 656.005(7)(a)(B).

The Court of Appeals affirmed. In rejecting the employer's argument that proposed surgery was not compensable because it was for a degenerative disc disease rather than the cervical strain, the court agreed with the Board's reasoning that, whether or not treatment was directed at the degenerative condition, compensability had been proven with medical evidence that the accepted cervical strain was and remained the major contributing cause of the claimant's disability and need for treatment. 120 Or App at 357-58. The court further noted that the medical evidence established that the "claimant's cervical strain made his degenerative disc disease symptomatic, resulting in the need for the surgery." Id. at 358. However, the court repeatedly indicated that compensability was proven because the medical evidence showed that the claimant's cervical strain, in combination with his degenerative disc disease, was the major contributing cause of the resultant condition. Id. at 356-59.

The holding in Burtis, therefore, is consistent with the court's interpretation of ORS 656.005(7)(a)(B) contained in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993). In Nazari, the court held that under ORS 656.005(7)(a)(B), when a work-related injury combines with a preexisting, noncompensable condition to cause disability or a need for treatment, the work-related injury is compensable only if it is the major contributing cause of the disability or need for treatment.

Here, the majority holds that claimant met her burden of proof under ORS 656.005(7)(a)(B) by merely showing that her compensable injury made her preexisting degenerative condition symptomatic, although the medical evidence establishes that the resultant condition--a herniated disc--was caused by the degenerative condition. Thus, the majority relates claimant's resultant condition to the compensable injury merely because the injury made the preexisting degenerative condition symptomatic. This conclusion is contrary to the provisions of ORS 656.005(7)(a)(B), which require that the entire "resultant condition" is compensable only if the compensable injury is and remains the major contributing cause. See Orville L. Lyons, 46 Van Natta 1509 (1994) (Board Member Neidig dissenting).

Here, unlike in Burtis, the medical evidence fails to establish that the accepted cervical strain is and remains the major contributing cause of claimant's disability and need for treatment. Rather, the medical evidence establishes that claimant's accepted strain has resolved and that her preexisting degenerative condition is the major contributing cause of her disability and need for treatment, including the surgery for her herniated disc.

The medical experts agree that claimant has preexisting degenerative disc disease. The medical evidence also establishes that this preexisting degenerative condition is the cause of claimant's symptoms. Dr. Franks stated the claimant's degenerative changes are significant and are the cause of claimant's neck pain. Dr. Rosenbaum opined that claimant's current symptoms were caused by her preexisting degenerative osteoarthritis. Dr. Rosenbaum further opined that the disc herniation was consistent with claimant's degenerative osteoarthritis, which was consistent with the natural aging process rather than the single injury of May 1991. He felt that the March 1991 injury did not worsen or accelerate the degenerative condition.

Dr. Zivin, neurologist, concurred with Dr. Rosenbaum's opinion. Dr. Zivin opined that the evolution of claimant's condition was consistent with degenerative disc disease and the natural aging process. He explained that claimant's findings were consistent with those of a modest degree of cervical spondylosis.

In conclusion, the medical evidence in this case shows that claimant's "resultant condition" for which she seeks treatment is in major part caused by her preexisting cervical condition. Therefore, claimant has failed to carry her burden of proof under ORS 656.005(7)(a)(B). Evidence that her preexisting condition was made symptomatic by her compensable injury and the Burtis case do not dictate a contrary result, especially in light of the fact of the initial absence of symptoms of neck pain radiating into the upper extremities) and headaches; an eventual resolution of the accepted cervical strain; claimant's ability to perform her regular work for 16 months, without time loss, following the May 1991 injury; and the lack of treatment for her compensable neck strain from October 1991 to September 1992. Because the relationship between claimant's accepted cervical strain and her herniated disc is too tenuous, I respectfully dissent.

In the Matter of the Compensation of
SENETRA SMITH-WAMPLER, Claimant
WCB Case Nos. 92-02811, 92-10294 & 92-12704
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Cummins, Brown, et al., Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The self-insured employer, Lower Umpqua Hospital (Lower Umpqua), requests review of those portions of Referee Howell's order which: (1) set aside its "back-up" denial of claimant's left neck/shoulder condition; and (2) upheld the SAIF Corporation's disclaimer of responsibility on behalf of Siuslaw Care Center (Siuslaw), a noncomplying employer. Claimant submitted a Motion to Strike Lower Umpqua's Appellant's Brief on the ground that SAIF was not timely provided with a copy of the brief. On review, the issues are motion to strike, "back-up" denial, compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Lower Umpqua's "back-up" denial of compensability did not include a disclaimer of responsibility.

On July 8, 1992, SAIF issued a disclaimer of responsibility for claimant's left shoulder condition, but did not request designation of a paying agent pursuant to ORS 656.307.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant filed a Motion to Strike Lower Umpqua's Appellant's Brief because SAIF was not served with a copy of the brief. Notwithstanding the fact that SAIF was not timely served with a copy of the brief, all parties submitted their respective briefs in accordance with the briefing schedule. Inasmuch as no party has been aggrieved by Lower Umpqua's alleged violation, we decline to strike its appellant's brief. See David F. Weich, 39 Van Natta 468 (1987).

Compensability

In October 1987, claimant injured her left shoulder while working for Siuslaw, a noncomplying employer. SAIF, as statutory claims processor for the noncomplying employer, accepted the claim as a disabling left shoulder strain.

On October 28, 1991, claimant injured her left shoulder while working for Lower Umpqua. On January 21, 1992, Lower Umpqua accepted claimant's claim as a disabling left shoulder strain. On April 8, 1992, Lower Umpqua issued a "back-up" denial of compensability of claimant's left shoulder injury

claim. On July 8, 1992, SAIF (on behalf of Siuslaw) issued a disclaimer of responsibility for the left shoulder condition.

Relying on Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993), Lower Umpqua argues that claimant did not have a compensable injury while working for Lower Umpqua because the major contributing cause of claimant's disability and need for treatment was claimant's preexisting somatoform pain disorder. The Referee found that claimant's October 1991 injury with Lower Umpqua had not combined with her preexisting noncompensable mental disorder, and therefore concluded that Lower Umpqua had not proven by clear and convincing evidence that claimant had not sustained a left shoulder injury in October 1991. See ORS 656.262(6). We agree with the Referee's conclusion.

Responsibility

The Referee next addressed the issue of responsibility of claimant's left shoulder condition as to Siuslaw (SAIF) or Lower Umpqua. The Referee determined that Lower Umpqua was responsible for claimant's left shoulder condition. We agree.

SAIF argues that the issue of responsibility should not have been addressed after the Referee concluded that Lower Umpqua had not proven by clear and convincing evidence that claimant had not sustained a compensable injury in October 1991. For the following reasons, we agree with SAIF's argument.

ORS 656.262(6) provides:

> "Written notice of acceptance or denial shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or the self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial. However, if the worker requests a hearing on such denial, the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable or that the paying agent is not responsible for the claim." (Emphasis supplied).

For the reasons expressed by the Referee, we conclude that Lower Umpqua has not proved by clear and convincing evidence that a left shoulder injury did not occur during claimant's employment in October 1991. See ORS 656.262(6). Thus, Lower Umpqua's prior acceptance remains in place. Lower Umpqua is responsible for further medical services and disability for claimant's left shoulder condition after October 28, 1991, until claimant sustains a new compensable injury involving the same left shoulder condition. See ORS 656.308(1); Smurfitt Newsprint v. Derosset, 118 Or App 368, 371 (1993). Inasmuch as Lower Umpqua's responsibility contentions pertain to a prior employer's coverage (Siuslaw) rather than to a subsequent employment exposure, we hold that Lower Umpqua remains responsible for claimant's left shoulder condition.

Because of Lower Umpqua's compensability denial, claimant's compensation remained at risk on Board review. Consequently, claimant's counsel is entitled to an attorney fee for his services on review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $700, to be paid by Lower Umpqua. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated October 12, 1993 is affirmed. Claimant's attorney is awarded $700 for services on Board review, to be paid by Lower Umpqua.

In the Matter of the Compensation of
ROBERT AAGESEN (BROWN), Claimant
WCB Case No. TP-94003
THIRD PARTY DISTRIBUTION ORDER
Pozzi, et al., Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

Claimant has petitioned the Board to resolve a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, claimant contends that the SAIF Corporation is not entitled to interest accrued ($4,047.70) on that portion of its lien which was held in trust pending the outcome of an appellate court's decision. We hold that claimant is entitled to the accrued interest.

FINDINGS OF FACT

In August 1985 claimant sustained a compensable injury when he fell from a ladder. SAIF accepted the claim and has provided benefits. Claimant retained legal counsel to initiate a third party action against the manufacturer of the ladder. With SAIF's approval, claimant and the third party settled claimant's cause of action for $50,000.

Thereafter, claimant asserted a legal malpractice claim against the attorney who represented him in the third party action. Claimant and the Professional Liability Fund proposed to settle this malpractice claim for $75,000. SAIF sought further recovery of its lien against the malpractice settlement. Claimant objected to SAIF's contention, arguing that the malpractice recovery was not lienable.

In October 1990, claimant and SAIF agreed to resolve their dispute concerning the malpractice settlement. In return for SAIF's approval of the settlement, claimant agreed to hold a mutually satisfactory amount in trust until the funds were disbursed by a court order or agreement of the parties. (Ex. 2). In an October 23, 1990 letter, SAIF's counsel informed claimant's counsel that SAIF would "wait on the Court of Appeals' decision(s) and allow the $32,000 to earn interest in your trust account." (Ex. 3). In an October 25, 1990 letter to SAIF's counsel, claimant's attorney stated that he would "hold the sum in trust until we either work out an agreement, or have a decision by the court or Board." (Ex. 4). In a return letter, SAIF's counsel indicated that his understanding of the agreement was that claimant's counsel would "retain approximately $32,000 in your trust account until such time as a court order or mutual agreement is determined." (Ex. 5).

On October 26, 1990, Attorney Thurber (SAIF's counsel) signed a "Release and Waiver of Lien Agreement," on behalf of SAIF, which stated that the parties "agree to hold a mutually satisfactory amount of the settlement funds under this agreement in trust until the funds are disbursed by court order or until such time as SAIF Corporation and Robert Aagesen and Laurie Aagesen mutually agree to the disbursement of the funds from the trust." (Ex. 2). Neither the agreement nor the letters between the two counsel indicated how the interest on the funds would ultimately be distributed.

At the time of this agreement, the Board had issued Charlene Toole, 41 Van Natta 1392 (1989) which supported SAIF's contention that a paying agency's lien extended to the proceeds from a legal malpractice settlement. Thereafter, claimant's counsel placed the disputed amount, $32,864.13, in an interest bearing trust account.

Subsequent to the parties' agreement, the Board's decision in Toole was reversed by the Court of Appeals. See Toole v. EBI Companies, 108 Or App 87 (1991). However, the court's decision was ultimately reversed by the Supreme Court in Toole v. EBI Companies, 314 Or 102 (1992) which held that a third party lien does attach to a legal malpractice recovery.

In late 1992, a dispute arose between the parties with regard to whether SAIF had relinquished its right to a share of the settlement proceeds prior to the Supreme Court's decision in Toole. SAIF petitioned the Board for resolution of the dispute. The Board concluded that SAIF had not relinquished its right to a share of the malpractice settlement. See Robert Aagesen, 44 Van Natta 2249 (1992). On January 26, 1994, the Board's order was affirmed by the Court of Appeals. Aagesen v. SAIF, 126 Or App 120 (1994).

On February 16, 1994, Ms. Jones, a SAIF Third Party Adjuster, wrote claimant's counsel pertaining to SAIF's third party share of the malpractice settlement. (Ex. 14). Ms. Jones indicated that by her calculations, SAIF's share was $33,333.33. In a February 18, 1994, claimant's counsel replied to Ms. Jones' letter, indicating that the correct sum of SAIF's share was $32,864.13 and asking for confirmation of that amount. (Ex. 15). By letter of February 24, 1994, Ms. Jones advised claimant's counsel that she agreed that SAIF's share was $32,864.13 and asked that the amount be forwarded as soon as possible. (Ex. 16).

A March 18, 1994 receipt, signed by Ms. Jones, stated that "[t]he sum of Thirty two-thousand Eight-hundred Sixty-four dollars and 13/100 ($32,864.13) is hereby accepted as payment in full of all amounts owed to SAIF on their third party lien regarding Robert Aagesen, claim number 4748775G, date of injury August 9, 1985." (Ex. 17).

Three days later, on March 21, 1994, SAIF's counsel wrote claimant's counsel requesting that a check in the amount of $32,864.13, plus accrued interest, be forwarded to SAIF. (Ex. 18). On March 30, 1994, SAIF's counsel again wrote claimant's counsel expressing concern that the interest accrued on the trust account balance was not forwarded to SAIF. (Ex. 19). On April 5, 1994, claimant's counsel wrote SAIF's counsel indicating that he had forwarded the amount agreed upon by Ms. Jones and further indicating that it was claimant's position that SAIF was not entitled to any further monies.

Unable to settle the "interest" dispute, the parties have submitted the question for Board resolution.

CONCLUSIONS OF LAW

If the worker or beneficiaries settle a third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(1); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory formula for distribution of a third party recovery obtained by judgment is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Thereafter, the worker shall receive at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). After those deductions, the paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under the workers' compensation law. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d); Liberty Northwest Ins. Corp. v. Golden, 116 Or App 64, 67-68 (1992).

When either a worker or the paying agency, in the course of negotiating a third party settlement, makes a representation to the other which could affect the other's position on the amount of the settlement, the other is entitled to rely on that representation. Williams, supra at p. 620. We applied this principle in Timothy J. Gheen, 43 Van Natta 1484 (1991).

In Gheen, the claimant agreed to honor a paying agency's $18,000 lien in return for the agency's approval of a third party settlement. Following the settlement, the claimant objected to a portion of the agency's lien which apparently pertained to a projected pain center program. Reasoning that the paying agency was entitled to rely on the claimant's representation that its lien would be honored, we declined to alter the parties' mutually agreed "just and proper" distribution. See also Robert L. Hardt, 45 Van Natta 1487 (1993) (Paying agency entitled to rely on the claimant's representation that its lien, consisting of CDA proceeds, would be honored when such representation was made in exchange for the paying agency's approval of a third party settlement).

Here, SAIF contends that claimant agreed that the interest accruing on the disputed amount would be distributed to the prevailing party. In support of this contention, it relies on an affidavit from its counsel (Attorney Thurber) which indicates that he and claimant's counsel had agreed to this during a phone call. However, claimant's counsel's affidavit indicates there was no such agreement. The correspondence between claimant's counsel and SAIF's counsels (Attorneys Thurber and Brickey) at the time of the parties' agreement concerning the distribution of the disputed amount does not support SAIF's contention. While most of the letters reference an interest-bearing account, none of the correspondence between the parties specifically states that the prevailing party will receive the interest accrued on the disputed amount.[1]

The only definitive conclusion which can be drawn from the parties' correspondence is that they agreed that the disputed amount was $32,864.13 and that the amount would be placed in an interest-bearing trust account. (Exs. 1-12). Consequently, on this record, it cannot be said that there was a mutual agreement concerning the eventual distribution of accrued interest. See Robert E. Greer, II, 43 Van Natta 650 (1991)(When parties had different understandings of a third party lien agreement, the Board relied on express language of the settlement document to resolve the dispute).

While there was no prior agreement between the parties regarding the distribution of the interest, Ms. Jones, on behalf of SAIF, did agree that $32,864.13 represented SAIF's share of the third party settlement. (Ex. 16). In addition, Ms. Jones accepted a check from claimant's counsel for that amount as payment in "of all amounts owed to SAIF on their third party lien." (Ex. 17). As of that point (if not prior to SAIF's approval of the third party settlement), SAIF's lien had been specifically quantified and it agreed it was not entitled to any further amounts. Moreover, in the absence of an agreement concerning the the interest, such amounts would accrue to claimant as SAIF is only entitled to its lien with the remaining balance payable to claimant. See Archie M. Ulbrich, 46 Van Natta 1517 (1994).

Were we to conclude that SAIF was entitled to the accrued interest, we would not only be reaching a decision inconsistent with the the parties' arrangement, but we would effectively be concluding that SAIF's lien exceeded the amount to which the parties agreed at the time the funds were distributed to SAIF. Such a conclusion would be inconsistent with the rationale expressed in the Williams, Gheen, and Hardt holdings. On this record (particularly where it is unclear whether the parties reached an agreement concerning entitlement to the interest) we are not prepared to reach such a conclusion.

Based on the aforementioned reasoning we hold that claimant is entitled to the interest accrued ($4,047.37). Therefore, claimant's counsel is directed to forward to claimant the aforementioned monies from counsel's trust account.

IT IS SO ORDERED.

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[1] Attorney Thurber's October 23, 1990 letter does mention the word "interest." However, it merely states that "[w]e will wait on the Court of Appeals' decision(s) and allow the $32,000 to earn interest in your trust account." Such a statement neither indicates to whom such interest would accrue nor does it state that the prevailing party will also receive the interest.

In the Matter of the Compensation of
DANY R. ARMSTRONG, Claimant
WCB Case No. 93-11266
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that portion of Referee Neal's order which declined to redetermine his unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the Referee's order with the following supplementation.

Before conducting a reevaluation of the extent of a claimant's permanent disability following closure of an aggravation claim, the claimant must establish a permanent worsening of his compensable condition since the last award or arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987). We rate a claimant's permanent disability as of the date of the reconsideration order. ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

Here, the Referee refused to redetermine claimant's unscheduled permanent disability, finding insufficient evidence that claimant's back condition had permanently worsened as a result of his May 1991 compensable aggravation claim. See Stepp v. SAIF, supra. Claimant contends that the medical evidence, including a medical arbiter's report, establishes a permanent worsening since the last arrangement of compensation in July 1988. We disagree.

When claimant's May 1991 aggravation claim was closed by a February 2, 1993 Notice of Closure, there was no medical evidence that claimant's condition had permanently worsened as a result of the compensable aggravation claim. Dr. MacKay, claimant's treating physician, had declared claimant medically stationary on November 17, 1992. His report, however, does not confirm a permanent worsening of claimant's low back condition. (Ex. 5).

Moreover, we note the earlier referee's order which found the May 1991 aggravation compensable. It described claimant's loss of earning capacity resulting from the aggravation as only "temporary." (Ex. 4). We are mindful that this finding does not preclude claimant from contending that there was a permanent worsening of his low back condition. See Hanes v. Washington County Community Action, 107 Or App 304 (1991) (preliminary finding by a referee that a claim was disabling did not preclude the employer from subsequently seeking a determination on extent of disability). However, the earlier referee's finding does not assist claimant in proving a permanent worsening. From our review of the evidence, we are unable to conclude that the May 1991 aggravation caused a permanent worsening of claimant's low back condition. Stepp v. SAIF, supra.

Claimant contends, however, that the medical arbiter's report, requested in conjunction with the February 1993 closure, establishes a permanent worsening of his compensable condition when compared to his condition in July 1988. He cites the arbiter's recommendations that he limit his work to the medium level and avoid frequent heavy lifting, bending, crawling, and stooping. (Ex. 10). Claimant's contentions notwithstanding, the arbiter's report is insufficient evidence of a permanent worsening of claimant's low back condition.

The arbiter's examination occurred on September 7, 1993, well after the February 2, 1993 Notice of Closure. In April, 1993, prior to the arbiter's examination, but after the February 1993 closure, Dr. MacKay, claimant's treating physician, recommended physical therapy for an aggravation or worsening of his low back condition. (Ex. 7). This recommendation subsequently resulted in a separate "aggravation" claim, which was considered under the Board's Own Motion authority. ORS 656.278(1). The Board declined to reopen the claim because no physician recommended surgery or hospitalization. (Ex. 8).

At hearing, claimant contended that the February 1993 closure had been premature. The Referee disagreed, finding that claimant's compensable condition was medically stationary. Claimant does not challenge the Referee's "medically stationary" ruling on Board review. Inasmuch as the claim has not been prematurely closed and since the claim has not subsequently been reopened retroactively to a

period encompassing the September 1993 medical arbiter examination, we proceed to consider the arbiter's report originating from that examination.

The arbiter's references to claimant's physical limitations do not confirm that the May 1991 aggravation permanently worsened claimant's low back condition. In fact, noting that claimant had experienced episodic low back pain for several years prior to his 1986 compensable strain, the arbiter questioned whether claimant's complaints were attributable to that injury. Given this, the arbiter's report is not persuasive evidence of a permanent worsening of claimant's compensable low back condition since the last arrangement of compensation in July 1988.

In conclusion, we agree with the Referee that the medical evidence does not demonstrate a permanent worsening of claimant's condition as a result of the May 1991 aggravation. Accordingly, claimant is not entitled to a redetermination of his unscheduled permanent disability.

ORDER

The Referee's order dated December 23, 1993 is affirmed.

August 22, 1994 Cite as 46 Van Natta 1667 (1994)

In the Matter of the Compensation of
RICHARD A. COLCLASURE, Claimant
WCB Case Nos. 88-15666 & 89-05949
SECOND ORDER ON REMAND
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys
Rankin, et al., Defense Attorneys
D. Kevin Carlson, Assistant Attorney General

On July 28, 1994, we withdrew our June 28, 1994 Order on Remand which: (1) affirmed Referee Leahy's order that found claimant entitled to vocational assistance; (2) affirmed Referee Nichols' order that declined to assess penalties and attorney fees for allegedly unreasonable claim processing; and (3) awarded a $4,000 attorney fee under ORS 656.388(1) for services rendered before the Board and appellate courts. We took this action to consider claimant's contentions that: (1) our attorney fee award was inconsistent with the $5,000 award previously granted by the Supreme Court; and (2) his attorney was entitled to an additional $1,250 fee for services performed before the Board on remand. Having received the self-insured employer's response, we proceed with our reconsideration.

To begin, the employer agrees with claimant's assertion that the Supreme Court's $5,000 attorney fee award takes precedence over the $4,000 award granted in our prior order. In light of the employer's concession, we withdraw that portion of our order which granted a $4,000 attorney fee award under ORS 656.388(1) for services rendered before the Board and appellate courts.

Turning to the issue of claimant's entitlement to an attorney fee award for services rendered before the Board on remand, the employer contests claimant's request for a $1,250 attorney fee award. Noting that claimant has not submitted an itemization of services performed on remand, the employer contends that there is no basis for determining whether the request is reasonable.

We disagree with the employer's assertion that the record is insufficiently developed to enable us to perform our statutory duty to determine a reasonable attorney fee award. Although a claimant's attorney may present information detailing his counsel's services (and the carrier may respond to that presentation), such a submission is entirely voluntary. See generally OAR 438-15-029. Because parties often choose not to avail themselves of these opportunities, we are often required to render an "attorney fee" determination based solely on the record developed concerning the merits.

Here, since the aforementioned rule does not address cases which are presented to the Board on remand, the rule is not applicable. Consequently, we proceed with our determination of a reasonable attorney fee based on the record as presently developed.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on remand is $750, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's supplemental briefs on remand), the complexity of the issues, and the value of the interest involved.

As a final matter, we note that our award has been limited to those services performed by claimant's counsel in regard to claimant's successful opposition to the Department's remand motion and claimant's eligibility for vocational assistance. To the extent that claimant's counsel's efforts were devoted to his opposition to the Department's motion to intervene, claimant's assertion that the Board lacked de novo review authority, and claimant's entitlement to penalties and attorney fees, such unsuccessful services do not entitle counsel to an attorney fee award.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our June 28, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICKEY L. PLATZ, Claimant
WCB Case No. 92-00249
ORDER ON REVIEW (REMANDING)
Ransom & Gilbertson, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Lipton's order that dismissed his request for hearing for lack of jurisdiction. In the event that the Board has jurisdiction over claimant's hearing request, claimant seeks remand. On review, the issues are jurisdiction, extent of permanent disability and remand. We remand.

FINDINGS OF FACT

Claimant compensably injured her left shoulder on July 24, 1990. Her claim was closed by a Notice of Closure dated May 22, 1991 which awarded 17 percent (54.4 degrees) unscheduled permanent disability. Claimant requested reconsideration of the Notice of Closure on July 15, 1991.

On September 3, 1991, an Order on Reconsideration issued which affirmed the Notice of Closure in all respects. The order acknowledged that claimant was entitled to a medical arbiter, but explained that the Director was required, by a circuit court judge's injunction, to issue a reconsideration order "regardless of whether the reconsideration process had been completed." Subsequent to the date of the Order on Reconsideration, claimant was examined by medical arbiter, Dr. Fry, who issued a medical arbiter report.

Claimant requested a hearing, which was designated as WCB Case Number 91-11623. On November 26, 1991, Referee Barber issued an Interim Order which held that the Order on Reconsideration was invalid on the grounds that the Appellate Unit had failed to consider a medical arbiter's report prior to issuing the order. On this basis, Referee Barber remanded the case to the Appellate Unit. By letter dated December 10, 1991, the Appellate Unit disagreed with Referee Barber's decision and declined to accept jurisdiction. Claimant requested Board review of Referee Barber's order.

On January 17, 1992, we issued an Interim Order concluding that Referee Barber's order was a final appealable order and holding that we had authority to consider the matters raised by claimant's request for review. Mickey L. Platz, 44 Van Natta 16 (1992). On May 28, 1992, we issued an Order on Review which found that the Board and Hearings Division lacked authority to remand a case to the

Appellate Unit, but which affirmed Referee Barber's conclusion that the Order on Reconsideration was invalid, and hence, jurisdiction remained with the Director. Mickey L. Platz, 44 Van Natta 1056 (1992). That order was not appealed within 30 days of its issuance.

On December 24, 1991 (within 180 days of the July 15, 1991 Notice of Closure), claimant filed the request for hearing in the present case. That hearing request was designated WCB Case Number 92-00249. The request for hearing raised the issue of the Department's failure to reissue an Order on Reconsideration which took into consideration the September 21, 1991 medical arbiter's report. At the time of hearing, claimant raised the issue of the extent of permanent disability.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's hearing request concerning the extent of permanent disability in WCB case number 91-11623 remained viable, the Referee dismissed claimant's hearing request in the present matter.

On review, claimant argues that her request for hearing in the present case should be joined with that in WCB Case Number 91-11623. In addition, claimant contends that the record has been incompletely developed concerning the issue of extent of permanent disability and she seeks remand for a new hearing on that issue. The self-insured employer contends that res judicata bars claimant's hearing request since she failed to appeal the Board's decision in WCB Case Number 91-11623.

We conclude that the Hearings Division has jurisdiction over claimant's hearing request in this case. Consequently, we remand for a hearing concerning the extent of claimant's permanent disability. We base our conclusion on the following reasoning.

Subsequent to our order in WCB Case Number 91-11623, the Court of Appeals held that the Director's failure to consider a medical arbiter's report did not invalidate the Order on Reconsideration. Pacheco-Gonzales v. SAIF, 123 Or App 312 (1993). Accordingly, contrary to our opinion in WCB Case Number 91-11623, the Hearings Division and the Board had jurisdiction to receive the medical arbiter's report and address the extent of claimant's permanent disability. However, our prior decision was not appealed and the issue in the present case concerns the effect, if any, of our prior decision on the current request for hearing.

In WCB Case Number 91-11623, Referee Barber concluded that the Appellate Unit's Order on Reconsideration was invalid, and that jurisdiction over this matter remained with the Director. On Board review in WCB Case Number 91-11623, we affirmed Referee Barber's conclusion that the Hearings Division lacked jurisdiction over claimant's hearing request. However, we modified that portion of the order which had remanded the claim to the Director. By holding that the Hearings Division lacked jurisdiction over claimant's request for hearing, Referee Barber (and the Board on review) effectively dismissed claimant's request for hearing in WCB Case Number 91-11623. The Board's order affirming Referee Barber's order with modification was not appealed and has become final. Thus, claimant's hearing request in WCB Case Number 91-11623 is no longer viable.

We conclude that Referee Barber's order, which held that the Department retained jurisdiction over the Order on Reconsideration, amounts to a dismissal of claimant's hearing request in WCB Case Number 91-11623. A referee's order of dismissal is interpreted by the Board as a dismissal "without prejudice" unless the order otherwise specifies. Julie Mayfield, 42 Van Natta 871 (1990); Robert L. Murphy, 40 Van Natta 442 (1988). Thus, since neither Referee Barber's order nor our subsequent order expressly dismissed claimant's hearing request with prejudice, the dismissal order was without prejudice.

Where a hearing request is dismissed without prejudice, the dismissal order does not have any preclusive effect on subsequent litigation. See Glenn L. Woodraska, 41 Van Natta 1472, 1476 (1989). Thus, the issues raised by that hearing request can be reraised at any time provided that the time limits set out by ORS 656.319 have been satisfied. See Ralph B. DePaul, 44 Van Natta 92 (1992) (The "reservation" of issues raised by a request for hearing amounts to a dismissal of those issues without prejudice; however, those issues can then be reraised as long as a new hearing is requested within the time limits set forth in ORS 656.319).

Here, after her hearing request in WCB Case Number 91-11623 was dismissed without prejudice, claimant was entitled to request another hearing provided that the new hearing request was made within 180 days of the date of the Notice of Closure. Claimant's current hearing request was filed on December 24, 1991, which is within 180 days of the July 15, 1991 Notice of Closure. Consequently, claimant's hearing request is timely. Accordingly, we conclude that the Hearings Division has jurisdiction to address the issue raised by that hearing request.[1]

In light of the Referee's conclusion that the Hearings Division lacked jurisdiction over this matter, the Referee concluded the hearing without admitting evidence or taking testimony. Under these circumstances, we find the record incompletely developed. Therefore, we find it appropriate to remand to Referee Lipton for further proceedings consistent with this order. ORS 656.295(5). These further proceedings may be conducted in any manner the Referee determines will achieve substantial justice. ORS 656.283(7).

ORDER

The Referee's order dated November 12, 1993 is vacated. The matter is remanded to Referee Lipton for further proceedings consistent with this order.

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[1] We distinguish this situation from the court's recent decision in Benzinger and Harris v. Oregon Department of Insurance and Finance, 129 Or App 263 (July 27, 1994). In Benzinger, the court reversed a circuit court order which had directed the Department to issue an Order on Reconsideration taking into account the findings of a medical arbiter panel. The Department had been previously ordered to issue an Order on Reconsideration. Benzinger v. Oregon Dept. of Ins. and Finance, 107 Or App 449 (1991). The Department followed that directive, but it issued its order prior to receiving a medical arbiter report. A referee subsequently set aside the reconsideration order and "remanded" the case to the Department with instructions to consider the "post-reconsideration order" medical arbiter report. When the Department refused to accept the remand, claimant sought relief from the circuit court. The Department appealed the circuit court's order which required it to issue another reconsideration order which had considered the medical arbiter report.

Relying on Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court reasoned that the referee lacked authority to remand to the Department. Consequently, the court concluded that the case was not properly before the Department and that the circuit court had erred in directing the Department to issue a new order.

In reaching its conclusion, the court sympathized with claimant's plight that he would never receive a hearing concerning the reconsideration order. Nevertheless, reasoning that claimant had created his current predicament, the court determined that claimant could not now ask for a second "bite of the apple" to remedy the very situation that resulted from claimant's choice of strategy.

Here, claimant's original request for hearing concerning the reconsideration order was dismissed without prejudice. However, claimant filed a subsequent request for hearing on the reconsideration order within the statutory time limit. Thus, unlike the claimant in Benzinger, claimant preserved his appeal of the reconsideration order. Consequently, the matter is properly before the Hearings Division.

In the Matter of the Compensation of
ALLAN R. ROEDER, Claimant
WCB Case No. 93-05356
ORDER ON REVIEW
Galton, Scott & Colett, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband and Haynes.

The SAIF Corporation requests review of Referee Crumme's order that set aside, as premature, its denial and disclaimer of responsibility for claimant's alleged aggravation claim. On review, the issues are the procedural propriety of the denial, and, if proper, compensability of claimant's aggravation claim.

We adopt and affirm the Referee's order, with the following supplementation.

We agree with the Referee that, at the time of denial, no claim for aggravation had been made, and thus, the denial was premature. Indeed, when queried, Dr. Thomas essentially declined to offer any opinion on any question concerning a potential claim. She and Dr. Frank (who evaluated claimant's condition) could not understand the reasons for claimant's symptoms, and they did not have or offer an opinion on the work-relatedness of claimant's condition. Thus, although SAIF had a duty to conduct an investigation to determine its obligations (if any) for claim processing, the conclusion it reasonably should have drawn from the information gathered, was that claimant's condition was being evaluated by the doctors and monitored by claimant's attorney, but that no aggravation claim had been made.

Parenthetically, we disagree with claimant's contention that all diagnostic services are compensable and that claimant must be diagnosed with a particular condition prior to the issuance of a denial. It is settled law that diagnostic services for the purpose of determining a causal relationship to an accepted claim are compensable. See Brooks v. D & R Timber, 55 Or App 688 (1982) (ORS 656.245 extends to payment for diagnostic procedures performed as a result of an industrial injury even when the procedures ultimately reveal that claimant's condition is not compensable); Kenneth M. Simmons, 41 Van Natta 378, recon 41 Van Natta 646 (1989) (An insurer must pay for diagnostic testing which is reasonable and necessary to determine a causal relationship, if any, between a compensable condition and a disease process); see also Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988) (The lack of a definitive diagnosis does not per se defeat a claim); Robinson v. SAIF, 78 Or App 581 (1986) (It is not a necessary predicate to compensability that the medical experts know the exact mechanism of a disease).

In any event, there is no indication in the record that there is a dispute regarding a billing for any particular diagnostic service. Hence, there is no such dispute before the Board.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the denial issue is $1,478, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 18, 1993 is affirmed. Claimant's attorney is awarded $1,478 for services on Board review, to be paid by the SAIF Corporation.

Board Member Haynes dissenting.

The majority concludes that claimant made no aggravation claim at the time SAIF denied his claim and that, therefore, SAIF's denial was premature. I respectfully dissent for the following reasons.

An insurer is free to partially deny any condition which it reasonably believes could be a claim. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989). A "claim" is "a written request for compensation from a subject worker or someone on the worker's behalf." ORS 656.005(6). "Compensation" includes all benefits, including medical services, provided for a compensable injury. ORS 656.005(8). The request does not have to take any particular form. A physician's report requesting medical services for a specified condition constitutes a claim. Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992). The lack of a definitive diagnosis does not per se defeat a claim, see Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); nor is it a necessary predicate to compensability that the medical experts know the exact mechanism of a disease, Robinson v. SAIF, 78 Or App 581 (1986).

Claimant compensably injured his neck in 1990. He experienced a left C5-6 herniated disc and left arm radicular symptoms for which a cervical diskectomy and fusion were performed. On January 15, 1993, claimant sought treatment from Dr. Thomson for progressive weakness, paresthesias and pain in his right arm. Claimant indicated to Dr. Thomson that he associated the pain in his right arm with pain in his upper spine. In a March 2, 1993 letter, SAIF questioned Dr. Thomson about the relationship of claimant's current right arm problem to the 1990 injury. Thus, as of March 2, 1993, Dr. Thomson's report had put SAIF on notice of, at least, a possible claim.

Then, on March 24, 1993, SAIF received a copy of a March 2, 1993 letter from claimant's attorney to Dr. Thomson, stating he was a workers' compensation attorney representing claimant with regard to his potential workers' compensation claims for injury to his upper and lower back. Two days later, on March 26, 1993, SAIF received a report from Dr. Frank in which he noted that claimant had reported pain in his right arm at the time of his 1990 injury. Dr. Frank's report was assigned to claimant's 1990 SAIF claim. (Ex. 29-1).

On April 1, 1993, claimant was sent to SAIF's examiners for an evaluation of his right arm pain. Claimant told them that he had had right, not left, arm pain after the 1990 surgery. In their report, they indicated that there was no relationship between the right arm pain and his 1990 disc injury on the left. On April 9, 1993, SAIF issued its denial.

Although no treating doctor opined that claimant's current right arm condition was related to his accepted 1990 neck injury or requested payment for medical services or time loss prior to SAIF's denial, each doctor reported claimant's history in which he alleged a relationship between his current right arm condition and his 1990 injury, as did SAIF's examiners. Consequently, I would conclude that claimant made a "claim" under ORS 656.005(6), which the employer appropriately denied under its reasonable belief that it could be a claim. Weyerhaeuser Co. v. Warrilow, supra.

In the Matter of the Compensation of
LOLA M. SPRINGER, Claimant
WCB Case No. 93-07471
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Referee Peterson's order that upheld the SAIF Corporation's denial of claimant's right shoulder, arm and hand condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Gilkey v. SAIF, 113 Or App 314, rev den 314 Or 573 (1992), SAIF argues that, because claimant and Liberty Northwest Insurance Corporation have entered into a Disputed Claim Settlement (DCS), the work exposure when Liberty was on the risk cannot be regarded as having

contributed to claimant's present condition. The employer was insured by Liberty from July 1, 1985 through June 30, 1991, and was insured thereafter by SAIF. SAIF contends that claimant must establish that her employment activities after SAIF was on the risk were the major contributing cause of her current condition. We disagree.

In Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994) (a decision issued subsequent to the Referee's order), the court rejected a similar argument. Claimant in that case had filed occupational disease claims for hearing loss against two employers and later entered into a DCS with the first employer. On Board review, we concluded that because the second employer was the only potentially responsible employer left in the case after claimant had entered into the DCS with the first employer, claimant had elected to prove actual causation against the second employer and could not rely on the last injurious exposure rule to establish compensability.

The court reversed, reasoning that there was no basis for allowing application of the last injurious exposure rule for assignment of responsibility but not as a rule of proof of causation when only one potentially causal employer remains in the case. Id. at 77. The court held that if a claimant can show that employment conditions, which may include conditions to which the claimant was exposed at the first employer, were the major contributing cause of the occupational disease, claimant may rely on the last injurious exposure rule to prove the compensability of the claim against a later employer by showing that employment conditions there could have caused the condition. Id. at 78.

In the present case, we must first determine whether claimant's employment conditions were the major contributing cause of her right shoulder, arm and hand condition.[1] See ORS 656.802(2). Although claimant's DCS with Liberty provided that her claim against Liberty shall remain denied, we may review whether claimant's work conditions during the period when Liberty was on the risk were the major contributing cause of her condition.[2] See Bennett v. Liberty Northwest Ins. Corp., supra. We rely on medical opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We tend to give greater weight to the conclusions of claimant's treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

Claimant was treated from 1982 to 1993 by Dr. Zimmerman, a chiropractor. Dr. Zimmerman reported that claimant first complained of upper back pain with arm and hand involvement in 1982. (Ex. 14). Dr. Zimmerman stated that claimant had been treated several times during the season when she works at the fruit packing house and said that her "history indicated infrequent flare-up of upper back and shoulder/arm symptoms, usually when she is sorting fruit." (Ex. 14). Between 1982 and 1993, Dr. Zimmerman's chart notes related claimant's treatment for her right shoulder, arm and hand condition to her employment on several occasions. (Ex. 2).

Dr. Brauer, claimant's family physician, treated claimant in February 1989 for acute left rotator cuff strain and he noted that "[t]his is almost certainly overuse syndrome." (Ex. 4). On October 25, 1990, Dr. Brauer found "[a]cute overuse syndrome of the musculature of the right shoulder girdle" and recommended that claimant "do as much sorting as she can with the left hand and avoid using the right arm as much as possible." (Id.) On February 11, 1993, Dr. Brauer reported that claimant had been "working as a fruit sorter for quite some time now and in the last 4 days she has noted increasing pain in the right shoulder area with radiation of discomfort into the right arm and some tingling into the right forearm and hand." (Id.)

In a "check-the-box" letter, Dr. Brauer stated that claimant's right shoulder condition was related to work. (Ex. 20). Dr. Brauer's review of the records noted a consistent pattern of shoulder complaints when claimant was engaged in working and packing and sorting. (Id.) Dr. Brauer agreed that claimant's shoulder condition originated in the 1980's and he considered her problem to be a recurrent condition that waxes and wanes depending on whether or not she is working. (Id.)

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[1] SAIF's denial referred to claimant's alleged occupational disease to her neck, upper back, right shoulder and low back. At the hearing, claimant said that her claim was for her right shoulder, arm and hand but did not include her back. (Tr. 28-29).

[2] Although claimant's DCS with Liberty is not a part of this record, we may take official notice of any fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(b). We have previously taken official notice of disputed claim settlements. See Kenneth W. McDonald, 45 Van Natta 1252 (1993).

On February 12, 1993, Dr. St. John, a chiropractor, treated claimant. Dr. St. John noted that claimant used her arms and wrists in repetitive motion and her pain seemed to increase after she got off work. (Ex. 5). On February 16, 1993, Dr. St. John stated that claimant's "injury stemmed from the repetitive motions her work entails. She should not be turning her wrists. The shoulder motion putting the fruit on the upper levels are also irritating her arm muscles and causing pinching of the nerves." (Ex. 8). Dr. St. John's February 22, 1993 report stated that claimant's "problems seem to derive from over use of her arms and wrists due to her job as a fruit sorter." (Ex. 9). In a "check-the-box" letter, Dr. St. John agreed that the major contributing cause of claimant's current right shoulder and arm condition was her employment that began in 1982 rather than her employment exposure since 1991. (Ex. 21).

Dr. Peterson examined claimant for SAIF and concluded that her current complaints were "definitely" not related to her employment. (Ex. 18). He reported that the etiology of claimant's condition is idiopathic. He noted that, although claimant had not worked for months at the time of his examination, she was still experiencing symptoms. (Id.)

Although Dr. Peterson said that the cause of claimant's condition was idiopathic, he did not explain what off-work activities could be causing her problems. Moreover, many of his comments are directed toward analyzing carpal tunnel syndrome, despite the fact that claimant has not filed a claim for that condition. In light of the numerous references in the chart notes of Drs. Zimmerman, Brauer and St. John that correlate claimant's right shoulder, arm and hand condition to her employment activities, we do not find Dr. Peterson's opinion that her condition was "definitely" not related to her employment to be persuasive.

We conclude that the opinions of Drs. Zimmerman, Brauer and St. John as a whole support the finding that claimant's work activities were the major contributing cause of her right shoulder, arm and hand condition. In reaching this conclusion, we note that no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

Although claimant worked for the same employer, the employer was insured by two insurers, Liberty and SAIF. Because claimant has shown that her employment conditions, which include conditions to which claimant was exposed when Liberty was on the risk, were the major contributing cause of her right shoulder, arm and hand condition, claimant may rely on the last injurious exposure rule to prove the compensability of her claim. Thus, to establish the compensability of her claim against SAIF, claimant must prove that her employment activities when SAIF was on the risk could have caused her condition. Bennett v. Liberty Northwest Ins. Corp., supra, 128 Or App at 78.

SAIF has been on the risk since July 1, 1991. On February 11, 1993, Dr. Brauer examined claimant and diagnosed acute right shoulder strain. (Ex. 4). Dr. St. John treated claimant in February 1993 for right arm and hand pain. (Exs. 8 & 9). As we noted earlier, both Drs. Brauer and St. John reported that claimant's problems resulted from her work activities. We conclude that claimant has established the compensability of her claim against SAIF by showing that employment conditions when SAIF was on the risk could have caused her condition. See Bennett v. Liberty Northwest Ins. Corp., supra.

The last injurious exposure rule can also be used by a carrier to avoid responsibility for a claim. See Runft v. SAIF, 303 Or 493, 501 (1987). Here, however, because claimant has entered into a DCS with the other potentially responsible insurer (Liberty), "responsibility" is not at issue and SAIF cannot use the last injurious exposure rule defensively. In SAIF v. Luhrs, 63 Or App 78, 83 (1983), the court said:

> "We believe the right to assert the [last injurious exposure] rule defensively depends on whether that single employer is the last employer where working conditions were such that they could have caused the disease. If so, the rule may not be asserted as a defense." (Emphasis added).

In the present case, because SAIF is the last employer where working conditions were such that they could have caused claimant's right shoulder, arm and hand condition, SAIF may not assert the last injurious exposure rule as a defense. See SAIF v. Luhrs, supra. Therefore, it is not necessary for us to perform a "responsibility analysis," i.e., to determine the "onset of disability" to decide which carrier is initially assigned responsibility and then to decide if responsibility should shift to another carrier. See Timm v. Maley, 125 Or App 396 (1993) (initial assignment of responsibility); FMC Corp. v. Liberty

Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223, rev den 299 Or 203 (1985) (shifting responsibility to an earlier carrier).

Finally, claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,800, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellant's brief, the hearing record, claimant's counsel's affidavit in support of an attorney fee award for services at hearing, and SAIF's objection to that affidavit), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated October 12, 1993, as amended on October 22, 1993, is reversed in part. The SAIF Corporation's denial of claimant's right shoulder, arm and hand condition is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $2,800 for services at hearing and review, to be paid by SAIF.

Board Member Haynes specially concurring.

Although I agree that we must apply the analysis used in Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), I write separately to express my agreement with the dissenting opinion in Bennett that when it is uncontroverted that a claimant's disability is caused by an exposure occurring during an earlier employment, there is no reason to apply the last injurious exposure rule even if the work exposure at the later employment could have contributed to the disability. 128 Or App at 80.

An employer/insurer should be able to use the last injurious exposure rule defensively as an equitable remedy. In Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984), the court said that the "last injurious exposure rule is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not." Furthermore, the court said that the rule does not "prevent an employer from proving that the claimant's disability was caused by a different employment." Id. I submit that the Bennett case violates that principle.

In Bracke v. Baza'r, 293 Or 239, 250 (1982), the court held that "employers have and may assert an interest in the consistent application of the last injurious exposure rules, either as to proof or liability, so as to assure that they are not assigned disproportionate shares of liability relative to other employers who provide working conditions which generate similar risk." In my opinion, the Bennett case unfairly applies the rule with "greater arbitrariness than is required to achieve its purposes." Id. at 250 n. 5.

In the Matter of the Compensation of
ZINAIDA I. MARTUSHEV, Claimant
WCB Case Nos. 93-11880, 93-11678 & 93-06337
ORDER OF ABATEMENT
Darris K. Rowell, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

Claimant requests reconsideration of our July 29, 1994 Order on Review, which upheld the self-insured employer's denial of her current psychological/gastrointestinal condition. Claimant asserts that the employer's denial is an invalid preclosure partial denial. See United Airlines, Inc. v. Brown, 127 Or App 253 (1994).

In order to further consider claimant's contentions, we withdraw our July 29, 1994 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, the Board shall proceed with its reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELVIN L. NELSON, Claimant
WCB Case Nos. 92-16492 & 93-01866
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer requested reconsideration of our May 6, 1994 Order on Review. On June 1, 1994, we abated our order to allow claimant an opportunity to respond. Having received claimant's response, and the employer's supplemental argument, we proceed with our reconsideration.

The case involves two separate claims, one for a right shoulder and the other for a neck condition and left foot injury. A Notice of Closure, which closed the right shoulder and neck condition claim, was affirmed by an Order on Reconsideration. However, a Determination Order, which closed the left foot injury claim, was rescinded by a February 5, 1993 Order on Reconsideration. Pursuant to the Order on Reconsideration, the employer resumed payment of temporary disability benefits.

The Referee found that both claims were prematurely closed and awarded additional temporary disability. Our order reversed and determined claimant's entitlement to permanent disability for each claim.

In its initial motion for abatement and reconsideration, the employer asserted that "[a]ll temporary disability benefits paid as a direct result" of the Referee's order "constitute an overpayment of benefits to which the employer is entitled to offset against the additional permanent partial disability that has been awarded." We understand the employer's initial memorandum supporting its motion as requesting an offset of temporary disability benefits it paid pursuant to the Referee's order.

ORS 656.313 in relevant part provides:

> "(1)(a) Filing by an employer or the insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs; and
>
> "(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed.
>
> "* * * * *
>
> "(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal."

We have construed ORS 656.313(2) as applying to requests for offset of temporary disability benefits paid pending appeal or review. E.g., Debbie L. Stadtfeld, 44 Van Natta 1474 (1992). In particular, we have found that temporary disability benefits paid pending appeal qualify under the statute as "compensation" and, because an offset would result in a "repayment" of the compensation, found such an action prohibited by the statute. See id. Based on Stadtfeld, we deny any request by the employer to offset temporary disability benefits it paid pursuant to the Referee's order pending review by the Board.

In its supplemental memorandum, however, the employer contends that it is "seeking authorization for an offset of time loss paid from February 5, 1993 to the date of the Referee's order against the additional permanent partial disability awarded by the Board." Specifically, the insurer argues that ORS 656.313(2) is not applicable to benefits paid before the hearing since they were not paid "pending the review or appeal."

In deciding whether ORS 656.313(2) is limited to benefits paid pending Board review and court appeal, we begin with an analysis of the text and context of the statute. E.g., PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). In particular, we first note that, because ORS 656.313(1)(a) refers to the filing of a request for hearing, request for review and court appeal, the use of the term "appealed" is most reasonably construed as referring to all three levels of appeal. In other words, in referring to the "compensation appealed" in subsection (a) and "order appealed" in subsections (A) and (B), we find that the legislature intended to include any appeal of the award of certain benefits, whether by filing a request for hearing, Board review, or court appeal.

Given this context, we similarly construe "appeal" in ORS 656.313(2) as referring to the three levels of review, including the request for hearing. Therefore, we conclude that the legislature intended to ensure that a claimant would not be obligated to repay compensation which was paid pending the filing of a request for hearing. Accordingly, we further conclude that the employer is not entitled to offset the temporary disability it paid pending the hearing.

Therefore, we deny the employer's request to offset temporary disability benefits paid pursuant to the February 5, 1993 Order on Reconsideration to the date of the Referee's order against the additional permanent disability awarded by our Order on Review. See ORS 656.313(2). On reconsideration, as supplemented herein, we adhere to and republish our May 6, 1994 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATHLEEN A. ROBINSON, Claimant
WCB Case No. 93-02515
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Claimant has requested reconsideration of our April 28, 1994 order affirming the order of Referee Mills. By his order, the Referee upheld the self-insured employer's denial of claimant's surgery and related treatment for an L5-S1 herniated disc that claimant sustained during a medical examination performed on the employer's behalf. Specifically, claimant argues that our reasoning in this case is inconsistent with the Board's decisions in Billie I. Ensley, 46 Van Natta 417 (1994), on recon 46 Van Natta 1077 (1994), and George Hames, Jr., 45 Van Natta 2426 (1993).

After we received the employer's response to claimant's request for reconsideration, it became apparent that neither party was aware of our recent Order on Reconsideration in Billie I. Ensley, supra. Accordingly, we withdrew our April 28, 1994 order and granted the parties the opportunity to submit further argument regarding the effect, if any, the Board's Order on Reconsideration in Billie I. Ensley has on this matter. Having received the parties' additional arguments, we proceed with our reconsideration.

In both Ensley and Hames, we held that an injury sustained during physical therapy administered for a compensable condition was itself compensable as a consequential condition under ORS 656.005(7)(a)(A). Claimant argues that she, like the claimants in Ensley and Hames, was required to participate in the activity -- in this case, a medical examination performed on the employer's behalf -- that caused her consequential condition. Therefore, claimant argues, because there is no meaningful distinction between this case and Ensley and Hames, we should hold that her current injury is compensable under ORS 656.005(7)(a)(A). We disagree.

In our original order in Ensley, we cited our order in Hames and said that, because the claimant had proven that her physical therapy regimen, which had been prescribed for a compensable low back condition, was the major contributing cause of her current neck condition, she had established the compensability of her neck condition under ORS 656.005(7)(a)(A). Billie I. Ensley, supra, 46 Van Natta at 417 (Order on Review).

On reconsideration of our order in Ensley, we acknowledged that our reasoning was based on an incorrect statement of the law. Billie I. Ensley, supra, 46 Van Natta at 1077 (Order on Reconsideration). Rather, citing Kephart v. Green Lumber, 118 Or App 76, rev den 317 Or 272 (1993) and Albany General Hospital v. Gasperino, 113 Or App 411 (1992), we concluded in Ensley that, because the claimant's neck condition was best characterized as a consequential condition, to establish the compensability of that condition, the claimant was required to prove that her compensable back condition was the major contributing cause of her neck condition. Because the uncontroverted opinion of the claimant's attending physician satisfied that standard, we concluded that the claimant's neck condition was compensable under ORS 656.005(7)(a)(A).

This reasoning comports with the Court of Appeals' interpretation of ORS 656.005(7)(a)(A).[1] In Albany General Hospital v. Gasperino, supra, the court explained:

> "[T]he major contributing cause standard of ORS 656.005(7)(a)(A) was not intended to supplant the material contributing cause test for every industrial claim. * * * The distinction is between a condition or need for treatment that is caused by the industrial accident, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the compensable injury. It is the latter that must meet the major contributing cause test." 113 Or App at 414 (footnote omitted; emphasis in original).

Subsequently, in Hicks v. Spectra Physics, 117 Or App 293 (1992), the court was required to determine the compensability of an injury that the claimant had sustained during an automobile accident when she was returning from medical treatment for a compensable injury. The court characterized the issue on appeal as whether the phrase in ORS 656.005(7)(a)(A), "consequence of a compensable injury," includes injuries that are the result of activities that would have not been undertaken but for the compensable injury. Id. at 296. After examining the legislative history to the 1990 amendment to ORS 656.005(7)(a)(A), the court concluded that the answer was "no," unless the compensable injury was the major contributing cause of the claimant's consequential condition. Id. at 296-97.

In Hicks, the claimant argued that the injuries she had sustained during the automobile accident were compensable, because they were work related. The court acknowledged that, under Fenton v. SAIF, 87 Or App 78, rev den 304 Or 311 (1987), the claimant would have been correct. However, the court concluded that, by amending ORS 656.005(7)(a)(A) in 1990, the legislature had overruled Fenton. As the court explained, "[u]nder ORS 656.005(7)(a)(A), any injury or condition that is not directly related to the industrial accident is compensable only if the major contributing cause is the compensable injury." Hicks v. Spectra Physics, supra, 117 Or App at 297 (emphasis in original). Concluding that the Board had applied the correct legal standard, the court affirmed the Board's conclusion that the claimant's consequential condition was not compensable. See id.

The court faced a similar situation in Kephart v. Green River Lumber, supra. In that case, the claimant sustained a compensable hand injury. Thereafter, he injured his shoulder during the course of a job trial as part of his vocational rehabilitation. The insurer denied the shoulder injury claim on the ground that the shoulder injury was a consequence of the hand injury and the claimant had not established that the hand injury was the major contributing cause of the shoulder injury.

The claimant in Kephart argued that his shoulder injury was compensable because it had occurred in the course of an authorized training program. The court agreed that, under its earlier decision of Wood v. SAIF, 30 Or App 1103 (1977), the claimant would have prevailed. However, the court concluded that amended ORS 656.005(7)(a)(A), as interpreted in Hicks v. Spectra Physics, supra, dictated a different result.

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[1] In 1990, the legislature amended ORS 656.005(7)(a)(A). Or Laws 1990, ch. 2, § 3. As amended, it provides:

> "A 'compensable injury' is an accidental injury or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." (Emphasis added).

The Kephart court reiterated that an injury or condition that is not directly related to an industrial accident is compensable only if the major contributing cause of the injury or condition is the compensable injury. Kephart, supra, 118 Or App at 76 (quoting Hicks v. Spectra Physics, supra, 117 Or App at 297). Because the injury that the claimant sustained during vocational rehabilitation was not directly related to his earlier compensable industrial accident, and because the compensable injury was not the major contributing cause of the consequential injury, the court concluded that the claimant's consequential condition was not compensable. See id. at 79. In reaching that conclusion, the court recognized that there is a distinction between traveling to and participating in vocational rehabilitation, but the court did not alter its holding. Id.

Here, claimant does not argue, nor does the evidence reveal, that her L5-S1 disc herniation was directly related to her compensable low back accident.[2] Accordingly, claimant's L5-S1 disc herniation is compensable only if her earlier compensable injury is the major contributing cause of the disc herniation. ORS 656.005(7)(a)(A); Hicks, supra, 117 Or App at 297; Kephart, supra, 118 Or App at 79; see also Charles D. Stevens, 46 Van Natta 1493 (July 20, 1994) (consequential injury occurring while picking up x-rays for carrier-requested medical examination held not compensable under ORS 656.005(7)(a)(A)).

Here, the evidence establishes that the major contributing cause of claimant's need for surgery was the new injury that she sustained during the medical examination. Her treating physician concluded that there was only a remote possibility that her current need for surgery was predominately related to her original compensable injury (see Ex. 89-2), whereas her treating surgeon was unable to render an opinion regarding whether her original injury was causally related to her current low back condition. (Ex. 90). Under the Court of Appeals' decisions interpreting ORS 656.005(7)(a)(A), and our Order on Reconsideration in Ensley, claimant's claim fails, because she has not established that her original compensable injury was the major contributing cause of her current condition.

In reaching this decision, we wish to emphasize the distinction between a consequential condition and a compensable consequential condition. The former includes those injuries that result from activities that would not have been undertaken but for a compensable injury, Hicks v. Spectra Physics, supra, 117 Or App at 296, such as traveling to physical therapy, id., participating in an authorized training program, Kephart v. Green River Lumber, supra, or, as in this case, attending a carrier-requested medical examination.

A separate inquiry is whether a consequential condition is compensable. To resolve that issue, we turn to the medical evidence. If that evidence persuasively establishes that the claimant's consequential condition was caused, in major part, by her original compensable injury, we will find the claimant's condition compensable. See, e.g., Billie I. Ensley, supra (order on reconsideration) (uncontroverted medical opinion of claimant's treating physician satisfied ORS 656.005(7)(a)(A)'s major contributing cause standard).[3]

We emphasize this distinction for the purpose of avoiding any misunderstanding regarding the breadth of our holding in this case. We hold only that, if a claimant sustains an injury while attending a carrier-requested medical examination, to be compensable under ORS 656.005(7)(a)(A), the claimant must establish that the compensable injury that necessitated the examination was the major contributing

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[2] If the evidence establishes that a claimant's current condition was directly related to an earlier compensable injury or disease, the material contributing cause standard applies. See ORS 656.005(7)(a); see also Gaylynn Grant, 46 Van Natta 468 (1994) (material contributing cause standard applied when evidence established that claimant's elbow condition, which arose while she was participating in an authorized training program, was directly related to an earlier compensable injury).

[3] In resorting to the medical evidence, we specifically rely on the expertise of the parties' medical experts with respect to the pathophysiology underlying the claimant's condition. However, we give no credence to a medical expert's legal conclusions. See, e.g., Jack E. Layton, Sr., 45 Van Natta 1501 (1993) (medical expert's "legal" opinion that the claimant's claim was not compensable held not persuasive). Therefore, we will give minimal, if any, weight to a medical opinion that concludes that a claimant's consequential condition is compensable based on the theory that, but for the fact that the claimant sustained a compensable injury, he or she would not have been engaged in the activity that gave rise to the consequential condition. See Hicks v. Spectra Physics, supra, 117 Or App at 296.

cause of the consequential condition. That a claimant is injured during a carrier-requested medical examination establishes that claimant has sustained a consequential condition cognizable under ORS 656.005(7)(a)(A). What remains to be determined, on a case-by-case basis, is whether the claimant has established by persuasive medical evidence that her original injury is the major contributing cause of her consequential condition. For the reasons set forth above, we conclude that, in this case, claimant has not met her burden of proof under that standard.

Finally, we note that claimant relies on our decision in George Hames, Jr., supra. In Hames, like Ensley, the claimant was injured during a course of physical therapy appropriately prescribed and administered for a compensable injury. We concluded that, because the sole need for physical therapy was the claimant's compensable injury, the physical therapy was the major contributing cause of the consequential condition. George Hames, Jr., supra, 46 Van Natta at 2428. Based on that reasoning, we further concluded that the compensable injury was the major contributing cause of the consequential condition. Id.

Because Hames (and, for that matter, Ensley) involved a consequential condition that arose from treatment of a compensable injury, we find Hames distinguishable from the instant case. Nevertheless, because the issues in Hames and this case are closely related, we write to express our views regarding the continued viability of Hames and the correct analysis of treatment-induced consequential conditions under ORS 656.005(7)(a)(A).

The special concurrence has determined that our order on reconsideration in Ensley is inconsistent with Hames; therefore, it concludes that Hames is no longer good law. We disagree. In both Hames and Ensley, the ultimate issue was whether the claimant's current condition was caused, in major part, by his or her compensable injury. On that ground, we find those cases consistent with each other.

Having said that, we recognize that there may be some confusion regarding the proper method for determining when, in a treatment-induced consequential condition case, the major contributing cause test of ORS 656.005(7)(a)(A) has been satisfied. We offer the following analysis.

We conclude that, when a consequential condition arises as the result of compensable medical treatment for a compensable injury, the compensable injury is the major contributing cause of the consequential condition if the medical evidence establishes that the compensable treatment was the major contributing cause of the consequential condition. See George Hames, Jr., supra; see also Rosa L. Sulffridge, 45 Van Natta 1152 (1993). In other words, ORS 656.005(7)(a)(A)'s major contributing cause standard will be satisfied if the claimant establishes that: (1) the medical treatment for a compensable injury was the major cause of a consequential condition; and (2) the medical treatment was materially related to the compensable injury. See ORS 656.245(1)(a); see also Beck v. James River Corp., 124 Or App 484 (1993) (material contributing cause standard applied to medical services claim for continued treatment necessitated by diagnostic treatment for compensable condition); Roseburg Forest Products v. Ferguson, 117 Or App 601, rev den 316 Or 582 (1993) (emergency treatment necessary to resuture surgical incision for compensable injury compensable as continued medical treatment bearing material relationship to compensable injury).

We note that, on its face, ORS 656.005(7)(a)(A) could be interpreted to preclude this conclusion. The statute provides that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." Arguably, that language could be interpreted as requiring, even in the context of a treatment-induced consequential condition, that there be medical evidence that the compensable injury was the major physiological cause of the consequential condition. The special concurrence advocates such an interpretation. Because we believe that it would be absurd to interpret ORS 656.005(7)(a)(A) to exclude coverage for consequences of compensable treatment for compensable injuries, we decline to interpret it so narrowly. See McKean-Coffman v. Employment Div., 312 Or 543, 549 (1992) (courts refuse to give literal interpretation to statutory language when to do so would produce absurd or unreasonable results).

We strongly disagree with the special concurrence that there is nothing absurd about giving ORS 656.005(7)(a)(A) the literal interpretation that it advocates. To do so would exclude from coverage the entire class of workers who sustain consequential conditions as a result of treatment for compensable injuries.

A classic example would be a worker who compensably injured her back, was placed on nonsteroidal anti-inflammatory drugs and then developed an ulcer because of the drug therapy. Under the view held by the special concurrence, unless the worker's back injury was physiologically the major contributing cause of the worker's ulcer, ORS 656.005(7)(a)(A) would preclude the worker from looking to her employer for payment for an obviously foreseeable consequence of her compensable back injury. In that situation, the worker would have no other avenue of recovery and the burden of the foreseeable consequence of a work-related injury would fall on the worker, the state (through some form of welfare), private insurance or the medical provider (when the worker's bills go unpaid). Because nothing in the text or context of ORS 656.005(7)(a)(A) persuades us that the legislature intended such an absurd result, we decline to construe that statute so narrowly.

By implication, the legislative history to ORS 656.005(7)(a)(A) supports our reasoning. In Hicks v. Spectra Physics, supra, the court summarized the legislative history, beginning with Representative Mannix' testimony:

> "'We keep the standard for compensability of an industrial injury itself as whether [the] work is a material contributing cause of a given condition, but as to consequential damages we do set up a major contributing cause analysis. And what [that] means is if you have a broken arm, that's industrial. And you're crossing a street on the way to see your doctor, and the doctor's office is right over there, and a car runs you down. Under current law, whatever happened to you in the street is included in workers' comp[ensation]. * * * [It's] considered a consequence of your industrial injury. You got hurt on the way to the doctor. Requiring major contributing cause means that no, being run down crossing the street on the way to the doctor is not covered. That's, to me, the most succinct example of the kind of change we are making there.' House Special Session, May 7, 1990, Tape 2, Side A." Hicks, supra, 117 Or App at 296-97 (brackets in original).

The court also referred to Senator Kitzhaber's explanation that "the major contributing cause standard would apply 'for things that you brought into the workplace or injuries that occur subsequent to the compensable injury * * *.' Interim Special Committee on Workers' Compensation, May 7, 1990, Tape 26, Side A at 150." Id. at 297 (Emphasis in original).

In view of Representative Mannix's and Senator Kitzhaber's testimony, we conclude that the legislature contemplated that the major contributing cause test of ORS 656.005(7)(a)(A) would apply to conditions that arise as a consequence of an intervening event or force independent of a claimant's original compensable injury. See Albany General Hospital v. Gasperino, supra. A motor vehicle accident on the way to treatment for the compensable injury is an example of such an intervening event. We glean from the legislature's silence that a medical condition that results from the treatment for a compensable injury is not such an intervening event. Rather, in view of the general policy of providing prompt, fair and reasonable benefits for persons who sustain work-related injuries or conditions, see ORS 656.012(2)(a), we conclude that ORS 656.005(7)(a)(A)'s major contributing cause standard will be satisfied if the claimant establishes that the consequential condition was caused, in major part, by medical treatment that was materially related to the underlying compensable injury or condition. See George Hames, Jr., supra; see also Rosa L. Sulffridge, supra.

Accordingly, on reconsideration, as supplemented herein, we republish our April 28, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Chair Neidig and Board Member Haynes specially concurring.

We agree with the majority's conclusion that, under ORS 656.005(7)(a)(A), claimant has failed to establish the compensability of the L5-S1 herniated disc that she sustained during a medical examination performed on the employer's behalf. We write to express our disagreement with the majority's analysis regarding the continuing viability of George Hames, Jr., 45 Van Natta 2426 (1993), in light of Billie I. Ensley, 46 Van Natta 417 (1994), on recon 46 Van Natta 1077 (1994), and its analysis of treatment-induced consequential conditions under ORS 656.005(7)(a)(A).

Before we proceed to the merits of these issues, we note that the majority's discussion regarding the proper analysis of consequential conditions that result from treatment of compensable conditions is dictum. Ordinarily, we would stay our hand and not respond to such dictum; however, given the majority's unnecessary interpretation of ORS 656.005(7)(a)(A), we feel it incumbent on us to respond at this juncture.

Our statement of the law in this Board's order on reconsideration in Ensley is inconsistent with the reasoning in Hames, but is consistent with the court's analysis in Hicks v. Spectra Physics, 117 Or App 293 (1992), and Kephart v. Green Lumber, 118 Or App 76, rev den 317 Or 272 (1993). In those cases, the court made it clear that, to establish the compensability of a consequential condition, the claimant must establish that the compensable injury was the major contributing cause of the consequential condition. Because this Board specifically relied on Hames in its original order in Ensley, in light of the correction of that order and the court's reasoning in Hicks and Kephart, we conclude that the analysis in Hames is no longer viable. For that reason, we do not consider Hames to be binding on the issue presented by this case.

Furthermore, we strongly disagree with the majority's conclusions regarding the interpretation of ORS 656.005(7)(a)(A) in the context of a treatment-induced consequential condition. The majority concludes that, if a claimant establishes that her compensable medical treatment was the major contributing cause of a consequential condition, she will also have proven that the compensable injury was the major contributing cause of the consequential condition under ORS 6565.005(7)(a)(A). We disagree.

In interpreting ORS 656.005(7)(a)(A), our task is to discern the legislature's intent. ORS 174.020. The best indication of legislative intent is the statutory language itself. Englander v. Thunderbird, 315 Or 633, 638 (1993). Only if the statutory language fails to reveal the legislature's intent is it necessary (or permissible) to resort to the context and history of the statute. See PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993).

The text of ORS 656.005(7)(a)(A) plainly reveals the legislature's intent. It provides that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." (Emphasis added). As cogently recognized in both Kephart v. Green Lumber, supra, and Hicks v. Spectra Physics, supra, that language clearly limits (without exception) the compensability of consequential conditions to those situations in which the compensable injury is the major contributing cause of the consequential condition.

The majority finesses this point by bringing ORS 656.245(1)(a) into the picture. However, that statute concerns the compensability of medical services and presupposes the existence of a compensable injury or condition. Nothing in that statute, nor the cases interpreting it, suggests that the legislature intended it to serve as a device for ascertaining, in the first instance, whether an injury or condition is compensable. We reject the majority's attempt to read ORS 656.245(1)(a) together with ORS 656.005(7)(a)(A) to reach a result that it seeks.

The majority's most egregious error is its decision to ignore language from Hicks v. Spectra Physics, supra, which it discusses at the onset of its order on reconsideration in this matter. See Stephens v. Bohlman, 314 Or 344 n.6 (1992) (when appellate court construes statute, that construction becomes part of statute). As the majority correctly states, in Hicks, the court characterized the issue on appeal in that case as whether the phrase in ORS 656.005(7)(a)(A), "consequence of a compensable injury," included injuries that resulted from activities that would not have been undertaken but for the compensable injury. Hicks, supra, 117 Or App at 296. The court concluded that the answer was "no," unless the compensable injury was the major contributing cause of the consequential condition. Id. at 296-97.

The majority has ignored this language, because to acknowledge Hicks' "but for" analysis would lead to a result that it wishes to avoid in treatment-induced consequential condition cases. Obviously, a claimant would not have undergone a prescribed course of medical treatment for a compensable injury but for the compensable injury. Therefore, under the plain directive of Hicks, a condition that results as a consequence of such medical treatment is compensable under ORS 656.005(7)(a)(A) only if the compensable condition, not the medical treatment itself, is the major contributing cause of the

consequential condition. In its effort to find that treatment-induced consequential conditions are uniformly compensable, the majority has improperly supplanted the causal relationship between the medical treatment and the consequential condition for the causal relationship between the compensable condition and the consequential condition. That reasoning violates both common sense and the principle that, when an appellate court construes a statute, that construction becomes part of the statute. See Stephens v. Bohlman, 314 Or 344, 350 n.6 (1992).

Finally, we reject the majority's attempt to rely on the maxim that adjudicative bodies need not interpret statutory language to reach absurd results. See McKean-Coffman v. Employment Div., 312 Or 543, 549 (1993). We find nothing absurd about the legislature deciding to increase a claimant's burden of proof in establishing the compensability of a consequence of the treatment of a compensable condition.

In sum, we conclude that, when a consequential condition arises as the result of medical treatment for a compensable condition, the claimant may prevail under ORS 656.005(7)(a)(A) only by establishing that the underlying compensable condition was the major contributing cause of the consequential condition. Kephart, supra; Hicks, supra. Because the majority has gone astray by concluding otherwise, we respectfully disagree with their reasoning. However, since such an analysis does not alter the result of this particular case, we specially concur.

August 23, 1994 Cite as 46 Van Natta 1683 (1994)

In the Matter of the Compensation of
MICHAEL J. SALDI, Claimant
WCB Case Nos. 93-00181 & 92-14128
ORDER ON RECONSIDERATION
Black, Chapman, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Claimant requests reconsideration of our June 24, 1994 Order on Review which upheld the self-insured employer's denial of claimant's current neck condition. Specifically, claimant contends that, given our finding that claimant was credible, we erred in our evaluation of the medical evidence.

On July 25, 1994, we withdrew our June 24, 1994 order for reconsideration. The employer's response to claimant's motion has been received. Accordingly, we proceed with our reconsideration.

Claimant contends that our finding that he was credible necessarily invalidates the opinion of Dr. Woolpert, because that opinion was based on the absence of a dramatic increase in symptoms while lifting a bumper at work. We disagree.

We found that claimant's credible testimony was essentially consistent with the history on which Dr. Woolpert relied. Specifically, we found that claimant experienced a gradual increase in symptoms following the bumper lifting incident, not a "dramatic increase in symptoms while lifting the bumper" as claimant contends. Therefore, our finding that claimant was credible does not invalidate Dr. Woolpert's opinion, nor does it transform Dr. Woolpert's opinion into one supporting compensability.

Furthermore, we continue to adhere to our finding that Dr. Purtzer's opinion does not establish, by a preponderance of the medical evidence, that claimant's work injury was the major contributing cause of his current condition, disability and need for treatment. Therefore, we adhere to our previous conclusion that claimant's current neck condition is not compensable.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 24, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA L. WHITING, Claimant
WCB Case No. C4-01575
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, et al., Claimant Attorneys
R. Michael Healey, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On June 23, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

By order dated July 28, 1994, the Board disapproved the parties' CDA on the basis that the agreement contained the following language:

> "IT IS FURTHER STIPULATED AND AGREED that this settlement shall resolve all issues or claims that were raised or could have been raised as of the date of the approval of this settlement." (P. 5, Ln. 12-14). Emphasis supplied).

We had previously disapproved a CDA which contained similar language. Victor F. Lambert, 42 Van Natta 2707 (1990). In Lambert, the proposed agreement stated that the parties agreed that the disposition resolved "all issues currently raised or raisable" concerning "outstanding claims for workers' compensation benefits, whether filed or not." (Emphasis supplied). Furthermore, the Board has disapproved CDA's involving or referring to denied claims. See Donald Rhuman, 45 Van Natta 1493 (1993); Frederick M. Peterson, 43 Van Natta 1067 (1991).

Accordingly, although the employer argued that its language was distinguishable from the language found in Lambert and pertained to only the accepted claim, we concluded that the broad language provided in the CDA did not contain any such limitations. Because the employer declined to amend the CDA or to correct the language to clearly provide for such a limitation, we found that the proposed disposition was unreasonable as a matter of law. See OAR 438-09-020(2)(b); Victor F. Lambert, supra.

On August 5, 1994, the Board received the parties' request for reconsideration. We find that the reconsideration motion was timely filed and is in compliance with OAR 438-09-035. Furthermore, we find good cause for the parties' additional submission. OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991). Accordingly, we proceed with our reconsideration.

On reconsideration, the parties propose that the following language be substituted in place of the language which was originally held to be objectionable. The parties' suggested provision provides:

> "It is further stipulated and agreed that this settlement shall resolve all issues that have been raised or that could have been raised before the Workers' Compensation Board concerning this Claim Disposition Agreement as of the date of the approval of this agreement."

After reviewing the parties' proposed language, we find that the provision is distinguishable from the provision found objectionable in Lambert, supra. Here, rather than referring to all claims raised or raisable between them, the parties have expressly limited their settlement to only issues pertaining to this CDA which are raised or raisable before the Board. Accordingly, by phrasing the CDA provision in this narrow and more precise fashion, we find that the provision no longer raises concerns regarding collateral claims or matters that either may not pertain to the accepted claim or that are not within the Board's authority to approve pursuant to ORS 656.236.[1]

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[1] We note that there can be no contention that medical services for the accepted claim are being settled by the CDA. First, we find that the parties' CDA specifically provides that claimant retains her right to medical services. Moreover, any attempt to settle medical services for the accepted claim is prohibited by statute and the Department's rules. ORS 656.236(1); OAR 436-60-145(1); Jean E. Nealy, 42 Van Natta 2378 (1990); Kenneth D. McDonald, 42 Van Natta 2307 (1990).

Because we now find that the language specifically pertains to claimant's accepted claim and this CDA, we conclude that such a provision is not unreasonable as a matter of law. Thus, we do not find any statutory basis for disapproving the amended agreement. See ORS 656.236(1). Accordingly, on reconsideration, the CDA, as amended, is approved. An attorney fee of $125, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

Board Member Gunn specially concurring.

I agree that the CDA, with the amended language, should be approved. However, I write separately to note that the parties' disposition is silent with respect to future penalty and attorney fee issues which may potentially arise if medical services (or processing or CDA payment issues) on this claim are someday the subject of a hearing. Therefore, by providing that "all issues" pertaining to this claim have been resolved, an insurer or employer could later contend that claimant has also waived her rights to penalties and attorney fees on those matters.

Although this CDA provides that only "issues" which could have been raised "as of the date of approval of the agreement" are being resolved, I believe that parties who do not wish to be unpleasantly surprised in the future will specifically provide, in the CDA, whether such penalties and attorney fees are being settled, or whether the disposition does not purport to settle such issues. At the present time, the Board reviews numerous CDA's which clearly state the parties' intent on penalties and attorney fees. In the future, I would encourage the parties to carefully consider the importance of such provisions, prior to signing the agreement.

In the Matter of the Compensation of
LESLIE C. MUTO, Claimant
WCB Case No. 93-10233
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Referee Crumme's order which determined that the insurer did not deny "de facto" claimant's left wrist condition. Claimant requests that we admit into evidence an Order on Reconsideration and medical arbiter's report not in existence at the time of the hearing. We treat claimant's submission of additional evidence as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and "de facto" denial.

We adopt and affirm the Referee's order with the following supplementation.

Remand

We may remand a case to the Referee for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the referee. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

With respect to claimant's request that we consider the February 10, 1994 Order on Reconsideration, we need not decide whether a remand is appropriate. The Board is able to take administrative notice of agency orders, such as a reconsideration order. See Mark A. Crawford, 46 Van Natta 725, 727 (1994). Regarding the January 31, 1994 medical arbiter's report, this evidence was not obtainable at the time of the November 24, 1993 hearing because it was not in existence. However, we deny claimant's motion for remand because the submitted evidence is not likely to affect the outcome of the case. That is, even considering this document, we agree with the Referee that the insurer did not deny "de facto" claimant's left wrist condition.

"De Facto" Denial

On July 6, 1992, claimant injured her left wrist when she struck it against the edge of metal machinery. Claimant filled out a form 801 for a "bruised left wrist." The initial diagnosis, however, was a "left hand contusion." (Ex. 4). Based on this diagnosis, the claim was formally accepted for that condition. (Ex. 5). Subsequent to this, claimant's treatment has been primarily directed at her left wrist. She has received numerous diagnoses for her left wrist condition. Claimant does not contend that the insurer has failed to pay for her medical treatment, and the insurer does not deny that claimant's left hand/wrist condition is compensable.

The Referee rejected claimant's contention that her left wrist condition had been denied "de facto" because, he concluded, claimant's current left wrist condition was the same condition that the insurer accepted, even though different diagnoses have been used to describe her condition. On review, claimant contends that the insurer denied the left wrist claim "de facto" because it accepted responsibility for a different body part, the left hand, when her injury was to the left wrist.

The case on which the Referee relied is controlling. See Teresa A. Olson, 45 Van Natta 1765 (1993). In Olson, the employer accepted a claim for a right trapezius strain based on a diagnosis given by an emergency room doctor. Claimant subsequently sought treatment from another physician, who diagnosed a cervicodorsal strain based on the claimant's complaints of neck and upper back pain. We held that no "de facto" denial of a cervicodorsal strain had occurred. We reasoned that, despite the different terminology used by each doctor, there was no medical evidence that claimant sought treatment for a new or different condition from the one accepted by the employer. Id.

This case is similar in that claimant has been given different diagnoses for her left wrist/hand condition. However, we agree with the Referee that there is no medical evidence that claimant has received treatment for a condition different from the one accepted by the employer.[1] While the initial diagnosis at the time of the insurer's acceptance was hand contusion, there is no evidence that claimant sustained separate injuries to the hand and wrist or that there are separate conditions resulting from her compensable injury. Indeed, claimant testified that there was only one injury, that involving her left wrist. (Tr. 17). Moreover, claimant's injury claim, which was accepted by the insurer, was for a bruised wrist.

Based on our review of the medical evidence and claimant's testimony, we are persuaded that claimant's current condition is the same condition that it has been since the original injury, even though different medical terminology has been employed. See Warren R. Friend, 46 Van Natta 1520 (1994) (Where diagnoses were used interchangeably, but the medical evidence established that the claimant had but one condition, no "de facto" denial found).

In conclusion, we agree with the Referee that no "de facto" denial of claimant's left wrist condition has occurred. Thus, we affirm the Referee's determination on this issue,

ORDER

The Referee's order dated December 28, 1993 is affirmed.

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[1] As the Referee notes, the possibility of a tear of the triangular fibrocartilagenous complex (TFCC), a left wrist ganglion and mild ulnar neuropathy across the cubital tunnel were raised by various physicians involved with claimant's treatment. The Referee found the medical evidence insufficient to establish that claimant has a left wrist ganglion or a TFCC tear. The Referee also determined that the medical evidence did not establish that claimant's work injury caused an ulnar neuropathy. Claimant does not dispute the Referee's findings concerning these conditions. Based on our de novo review of the medical evidence, we agree with the Referee's findings.

In the Matter of the Compensation of
ROBERTO R. CASTILLO, Claimant
WCB Case No. 93-05479
ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
Lundeen, et al., Defense Attorneys

The insurer requests reconsideration of our July 13, 1994 Order on Review which set aside the insurer's denial of claimant's injury claim for a lumbar strain and right trapezius strain. On August 11, 1994, we withdrew our July 13 1994 order for further consideration. Having received claimant's response, we proceed with our reconsideration. For the following reasons, we adhere to our July 13, 1994 order.

The insurer argues that, in light of contravening evidence, it is inconsistent to find that claimant testified untruthfully in some instances, but told the truth as to the lifting events that injured his back on January 28, 1993. Specifically, the insurer contends that, although the Board implicitly found the testimony of Mr. Jarrell persuasive, it rejected Mr. Jarrell's statements that the event at work, as recounted by claimant, did not occur. Finally, the insurer asserts that we erroneously rejected the testimony of other witnesses who did not support claimant's version of the relevant events.

First, we did not find Mr. Jarrell's testimony persuasive. In fact, based on our review of the record, we doubt the reliability of Mr. Jarrell's testimony.

Mr. Jarrell testified to a veritable certainty that claimant never lifted barrels once. He was adamant, therefore, that claimant did not lift barrels on January 28, 1993. Jarrell was certain claimant had lied about the lifting incident because "I don't see him doing any of it." (Tr. 58). Even independent of claimant's testimony, the record establishes otherwise. Ms. McNett, claimant's supervisor, testified that she observed claimant lifting barrels occasionally (Tr. 38, 45). Thus, although the record is far from clear concerning how often claimant lifted barrels, it is clear that contrary to Jarrell's stated certainty, claimant did lift barrels at work.

Our conclusion on the ultimate question is likewise not changed by the testimony of Mr. Nolan, a co-worker, and Mr. Dickson, Vice President of Operations. Nolan's testimony that he and Mr. Jarrell routinely emptied the barrels, and that he never saw claimant perform such duties, does not require a conclusion that claimant did not lift a barrel on the particular day in question. Likewise, Mr. Dickson's testimony concerning maintenance procedures, and water in the barrels, generally, does not persuasively rebut claimant's recollection that he experienced back pain while lifting a barrel containing water and pellets.

In conclusion, we acknowledge that claimant was not entirely truthful in presenting his testimony. Nevertheless, for the reasons expressed in our prior order, and further detailed above, we adhere to our conclusion that claimant established a compensable injury claim.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the request for reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, as supplemented herein, we adhere to and republish our July 13, 1994 Order on Review. For services on reconsideration, claimant's attorney is awarded an assessed attorney fee of $500, payable by the insurer. The parties' rights of appeal shall begin to run from this date.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN A. HOFFMEISTER, Claimant
WCB Case No. 93-00513
ORDER ON REVIEW
Olson Law Firm, Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

The self-insured employer requests review of Referee Holtan's order that set aside the employer's denial of claimant's occupational disease claim for Hepatitis C exposure. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Relying primarily on the opinions of Dr. Jui, infectious disease specialist, the Referee concluded that claimant had established that he had the Hepatitis C virus and that the condition was caused, in major part, by his employment as a police officer for the employer. The employer argues that claimant has failed to meet his burden of proof under ORS 656.266 because, at most, the evidence merely disproves other possible non-work related causes for claimant's condition.[1] We agree that claimant's condition is not compensable, but not for the reason argued by the employer.

Claimant has the burden of establishing that his Hepatitis C was caused, in major part, by his work for the employer. ORS 656.802(2). Claimant may not carry that burden "merely by disproving other possible explanations of how the injury or disease occurred. ORS 656.266 (emphasis added); see Ruben G. Rothe, 45 Van Natta 369 (1993).

In a letter to claimant, Dr. Jui stated:

> "Tests prove that you have been exposed to the Hepatitis C virus. As physician supervisor for the Portland Fire Bureau, I have seen several similar cases where fire, police and paramedic personnel acquire such diseases through exposure to blood and other bodily fluids. Although it is impossible to determine beyond a reasonable doubt, it is my conviction that you most likely acquired the Hepatitis C infection as a consequence of your employment." (Ex. 1).

In a subsequent report, Dr. Jui stated:

> "I have taken an extensive history and examined [claimant]. Through the process of elimination of all other high risk categories, the most probable method of acquisition of antibody to hepatitis C is by exposure in the role of his employment as a police officer for the [employer]." (Ex. 2-2) (emphasis added).

We conclude that Dr. Jui's opinions did more than "merely" disprove other possible non-work related explanations for claimant's Hepatitis C. Rather, Jui relied on his experience with other police officers and fire fighters who have contacted blood-borne diseases from work activities, and concluded that claimant probably contracted the virus during his work as a police officer. On this record, we decline to discount Dr. Jui's opinion on the ground that it "merely" disproved other non-work causes for claimant's Hepatitis C.

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[1] The employer also argues that claimant has not established that he has Hepatitis C. We need not address that issue because, even assuming that claimant has Hepatitis C, we conclude that his claim fails for lack of sufficient evidence that his condition is work related.

Nevertheless, we agree with the employer that claimant has failed to meet his burden of proof. To prove the compensability of his Hepatitis C condition, claimant must show that his work exposure was the major contributing cause of that condition. ORS 656.802(2).

Claimant's theory of compensability is based on the premise that, as a police officer, he came into contact with a population that had a statistically significant incidence of Hepatitis C infection, so that random contact with body fluids from that population would likely cause him to develop Hepatitis C. We conclude that there is insufficient evidence in this record to support that premise.

Dr. Jui asserted that he had seen police officers and fire fighters who had contracted diseases through exposure to blood and other bodily fluids. However, there is no evidence in this record that establishes that police officers regularly come into contact with persons who are actually infected with Hepatitis C; the record is silent regarding the incidence of Hepatitis C in the population that police officers interact with. See Lorraine M. Person, 41 Van Natta 1831 (1989) (claimant failed to prove compensability of hepatitis condition, in part, because she failed to present any evidence regarding the incidence of hepatitis in population to which she was exposed).[2]

Regarding the occupational risk of police officers contracting Hepatitis C at work, Dr. Jui stated:

> "The current method of transmission of [Hepatitis C] is thought to be very similar to that of hepatitis B; specifically parenteral transmission (needlesticks, exposure to blood) is thought to be the primary transmission route (aside from transfusions, dialysis, and intravenous drug use). Literature prior to hepatitis B immunization has revealed that EMTs and Paramedics have a much higher seroprevalence of antibodies to hepatitis B (estimated 15% - 20%) than the normal population in the United States ([less than] 5%).
>
> "Law enforcement personnel often function in the role of first responder and should be classified as EMS personnel. Given that the method of acquisition is similar to that of hepatitis B and that hepatitis B has a much higher seroprevalence in first responders and EMS personnel, it is logical to assume that the epidemiology of hepatitis C is similar and this is a significant occupational infectious disease risk." (Ex. 2-2) (emphasis added).

Dr. Jui and the employer's expert, Dr. Benner, gastroenterologist, agreed that at least 40 percent of Hepatitis C cases have an unknown etiology. (Exs. 2-1, 3-2). Dr. Benner elaborated:

> "Moreover, among asymptomatic blood donors found to be positive for anti-HCV [the Hepatitis C antibody], approximately 75% of them had no evidence of parenteral blood exposure. Based on the information noted that health care workers have a 2-4% incident [sic] of positive anti-HCV, which represents only approximately two- to threefold increase above the incidents [sic] in the general population (1-2%) and that the risk is greatest among individuals with consistent potential exposure to blood products (surgeons, dentists, emergency room personnel), it is difficult to establish that persons with infrequent blood exposure (i.e., police officers without specific parenteral exposure) experience [Hepatitis C Virus] transmission related to their work as opposed to other as yet unidentified routes of transmission, which is responsible for 40% of the HCV in the general population." (Ex. 3-2) (emphasis added).

In light of the uncontroverted evidence that at least 40 percent of persons with Hepatitis C contract the disease from an unknown route, and the absence of evidence regarding the incidence of Hepatitis C cases among the population with whose body fluids claimant came into contact, we are most persuaded by Dr. Benner's opinion to the effect that it is not possible to determine, with medical

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[2] Indeed, there is only scanty evidence regarding the incidence of Hepatitis C generally. Dr. Jui stated that the virus is detected in 0.05 to 1.0 percent of blood donors (Ex. 2-2), while the employer's expert, Dr. Benner, stated that, in the general population, there is a 1 to 2 percent incidence of Hepatitis C. (Ex. 3-2).

There is also no evidence that any individuals with whose body fluids claimant came into contact had Hepatitis C.

probability, the source of claimant's Hepatitis C. See Lorraine M. Person, supra; compare John W. Walters, 45 Van Natta 55 (1993), aff'd mem Orkin Lawn Care v. Walters, 125 Or App 338 (1994) (ubiquitous environmental fungus held to be cause of the claimant's disseminated sporotrichosis). Without more, Dr. Jui's assumption that Hepatitis C is a "significant occupational infectious disease risk" for law enforcement personnel is not sufficient to establish that claimant contracted Hepatitis C through his work activities.

For the foregoing reasons, then, we conclude that claimant has failed to establish the compensability of his Hepatitis C condition. Accordingly, we reverse the Referee's decision setting aside the employer's denial of that condition.

ORDER

The Referee's order dated September 20, 1993, as reconsidered November 9, 1993, is reversed. The self-insured employer's denial is reinstated and upheld in its entirety. The Referee's attorney fee award also is reversed.

Board Member Gunn dissenting.

The majority concludes that, because the record is silent regarding the incidence of Hepatitis C in the population with whom police officers interact, claimant has failed to establish the compensability of his Hepatitis C condition. Because I disagree, I dissent.

Before I address the majority's analysis, I consider whether claimant has established the existence of his Hepatitis C condition. The evidence reveals that claimant twice tested positive for the Hepatitis C antibody. The testing method used on claimant has between a 20 and 50 percent incidence of false positives. Nevertheless, Dr. Jui, treating physician, concluded that, notwithstanding the testing method used on claimant, the two positive tests results supported the conclusion that claimant had been exposed to the Hepatitis C virus. (See Exs. 1, 2, 4-27). In the absence of any persuasive reasons not to defer to Dr. Jui's opinion, see Weiland v. SAIF, 64 Or App 810 (1983), I would hold that claimant has established by the preponderance of the evidence the existence of his Hepatitis C condition.

The employer argues that claimant's claim fails because he cannot prove that he was ever exposed to Hepatitis C. In light of evidence that claimant intermittently came into contact with body fluids of other persons at work, and the test results showing the presence of the Hepatitis C antibody (Ex. 4-31), I would find that there is sufficient evidence that claimant has been exposed to the Hepatitis C virus.

I turn to the causation issue. On this record, I would conclude that it is more likely than not that claimant was exposed to Hepatitis C at work. There is absolutely no evidence of any non-work exposure to Hepatitis C (such as intravenous drug use). There is, however, uncontroverted evidence that claimant came into contact with body fluids, including blood, of some of the persons to whom he was exposed during his work as a police officer. Indeed, the record establishes that the greatest risk of exposure to Hepatitis C was claimant's work. This led Dr. Jui to conclude that claimant's work probably was the major cause of his Hepatitis C condition. (Exs. 2-2, 4-27). In light of Dr. Jui's experience in treating fire, police and paramedic personnel who have Hepatitis C, and the lack of any reason not to defer to his opinion, see Weiland v. SAIF, supra, I would hold that Dr. Jui's opinion is sufficient to establish the compensability of claimant's Hepatitis C condition.

The majority concludes that, because there is no evidence regarding the incidence of Hepatitis C among the population that police officers serve, claimant has failed to meet his burden of proof. I disagree. The record establishes approximately a 1 to 2 percent incidence of Hepatitis C in the general population, which would include those persons to whom claimant was exposed at work. (See Ex. 3-2). Although that is a low incidence rate, I would conclude that, in the absence of any evidence of other potential risk factors for claimant's Hepatitis C exposure, that incidence rate is sufficient to establish that claimant was at risk for contracting Hepatitis C when he was exposed to other persons' body fluids at work.

The insurer argues that claimant's claim fails because he has not specifically identified the particular incident in which he was exposed to the Hepatitis C virus. That argument is without merit. As the medical evidence shows, claimant is in a "high risk" occupation, in that the likelihood of exposure to toxic substances, such as blood and other body fluids, is much greater than in comparison to that of the general population. In other words, as in those cases concerning asbestos exposure, claimant need only show that the working environment has a toxin; claimant was exposed to such toxin; and the exposure was the major contributing cause of the occupational disease. On this record, there is more than sufficient evidence to satisfy all three of those requirements.

Lastly, I am concerned that, in this case, the Board is raising the degree of evidentiary proof required to establish the compensability of complex diseases such as Hepatitis C. Claimant's burden is to establish by a preponderance of the evidence -- that it is more likely than not -- that he contracted Hepatitis C at work. He is not required to show sole causation or proof beyond a reasonable doubt. Yet, by imposing on claimant the onerous requirement that he submit evidence that addresses the incidence of Hepatitis C in the precise population to whom he was exposed, I fear that the majority has done just that. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
RAMON M. MARIN, Claimant
WCB Case No. 92-07796
ORDER ON REMAND
Francesconi & Busch, Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Marin, 128 Or App 161 (1994). The court has reversed our prior order, Ramon M. Marin, 45 Van Natta 1606 (1993), which held that claimant's injuries to both legs, knees and right ankle were compensable because they had occurred in the SAIF Corporation's insured's parking lot. Citing Norpac v. Gilmore, 318 Or 363 (1994), the court has concluded that we neglected to examine the causal connection between claimant's employment and his injuries to determine if he had shown a sufficient work-connection to establish the compensability of his claim. Consequently, the court has remanded for reconsideration. On reconsideration, we affirm the Referee's order setting aside SAIF's denial.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On January 8, 1992, after completing his shift with his employer, claimant walked to his truck, which was parked in a lot leased by the employer for use by its employees and customers. Claimant could not start his truck, because the battery was dead. He waited approximately half an hour for other employees to get off work so that he could ask one of them for a jump start.

A supervisor's car was parked near claimant's truck. At claimant's request, the supervisor agreed to give claimant a jump start. The jumper cables were not long enough to connect the two vehicles, so the supervisor's wife moved the supervisor's car closer to claimant's truck. In the process of that move, the supervisor's car struck a flower box, which in turn was pushed into claimant, squeezing him against his truck and resulting in injuries to his legs, knees and right ankle. The employer had built the flower box that struck claimant.

When SAIF denied claimant's injury claim, claimant requested a hearing. Finding that claimant had established a sufficient connection between his employment and his injury, the Referee set aside SAIF's denial. SAIF requested Board review.

In our first order, we adopted and affirmed the Referee's order, with supplementation. Relying on Boyd v. SAIF, 115 Or App 241, 244 (1992), we reasoned that, "because claimant's injury occurred while he was attempting to leave work and in a parking lot controlled by the employer," claimant had proven a work relationship sufficient to establish legal causation. Ramon M. Marin, supra, 45 Van Natta at 1607.

SAIF petitioned for judicial review of our order. Relying on Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the Court of Appeals reversed our decision. SAIF v. Marin, supra. In Gilmore, the court reiterated that, to establish the compensability of an injury, including those that occur on employer-controlled parking lots, the claimant must establish that the injury: (1) occurred "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, supra, 318 Or at 366.

Concluding that the Board had considered only the "in the course of" element of the work-connection test, the Court of Appeals has remanded this case to us for consideration of whether claimant's injuries "arose out of" his employment. SAIF v. Marin, supra.

The Referee reasoned that, because claimant's injury had occurred on a parking lot controlled by his employer and because claimant had a legitimate reason for remaining at the parking lot after the completion of his shift, claimant's injuries were sufficiently work-connected to be compensable. The Referee did not expressly address whether claimant's injuries had arisen out of his employment.

As we stated earlier, to establish that an injury "arose out of" employment, the claimant must prove that there is some causal connection between the injury and his or her employment. Norpac Foods, Inc. v. Gilmore, supra, 318 Or at 368-69. In a "parking lot" case, that causal connection exists when the claimant's injury was brought about by a condition or hazard associated with premises over which the employer exercises some control. See Montgomery Ward v. Malinen, 71 Or App 457 (1984) (fall on icy pavement employer had legal duty to maintain); Ronald. R. Nelson, 46 Van Natta 1094 (1994) (fall on rough pavement on employer-controlled driveway); see also William F. Gilmore, 46 Van Natta 999, 1000 (1994) (order on remand) (injury sustained while the claimant entered his vehicle on employer's parking lot held not compensable, because it did not arise from risk associated with the lot). In other words, claimant must prove that his employment conditions put him in a position to be injured. See Henderson v. S.D. Deacon Corporation, 127 Or App 333 (1994).

At hearing, the parties stipulated that the employer had built the flower box that was pushed into claimant. Accordingly, we conclude that the flower box was a hazard associated with the parking lot over which the employer exercised control. See William F. Gilmore, supra; Ronald R. Nelson, supra.[1] Because claimant was injured when the flower box was moved out of place, thus trapping claimant in between the box and his truck on the employer's parking lot, we conclude that claimant's employment conditions put him in a position to be injured. See Henderson v. S.D. Deacon Corporation, supra. Therefore, we conclude that the causal connection between claimant's injuries and his employment is sufficient to establish that his injuries "arose out of" his employment.

This case is distinguishable from William F. Gilmore, supra. There, after completing his work for the day, the claimant walked to his car, which was parked on the employer's parking lot. While he got into his car, the claimant's knee "grabbed" or "locked up", producing excruciating pain. Claimant was later treated for a knee injury. There was no evidence that the employer's parking lot had exposed the claimant to any risks different from those encountered by any person getting into his car; rather, it appeared that claimant's knee problem was idiopathic. See id., 46 Van Natta at 1000. Accordingly, we concluded that the claimant's injury did not "arise out of" his employment. Id.

Here, in contrast, the cause of claimant's injuries is attributable to a condition on the employer's parking lot, namely, the flower box that was pushed into claimant. In that regard, this case is akin to Ronald R. Nelson, supra, and Montgomery Ward v. Malinen, supra, where the claimants' injuries arose as a result of hazards on the employers' parking lots, not conditions peculiar to the claimants. Because claimant's injuries arose as the result of a hazard on the employer's parking lot, and not a condition peculiar to claimant, we conclude that his injuries "arose out of" his employment.

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[1] We reach this conclusion even though the flower box struck claimant only after the box had been moved by the supervisor's car. Whether or not the employer was "negligent" in the placement of the flower box is not the issue, as this is not an action for negligence. For our purposes, an employer-created "condition" or "hazard" can exist without any "negligence" on the employer's part.

For these additional reasons, we agree with the Referee that claimant has established the compensability of his injury claim for both legs, knees and right ankle.[2]

Claimant has finally prevailed after remand with respect to whether his injuries arose out and in the course of his employment. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991). Because as we have affirmed the Referee's order setting aside SAIF's denial and awarding an assessed attorney fee of $2,000, it is unnecessary to address claimant's entitlement to an attorney fee for services at the hearing level. Likewise, we republish our prior attorney fee award of $1,000 for services on Board review. Thus, we proceed to address claimant's attorney fee at the court level.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services at the Court of Appeals level is $2,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, we affirm the Referee's order dated September 21, 1992. Claimant's attorney shall receive an attorney fee of $2,000, payable by the SAIF Corporation, for services rendered before the court, in addition to the attorney fee awards previously granted by our prior order and the Referee's order.

IT IS SO ORDERED.

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[2] In its brief to the Court of Appeals, SAIF asserted that we erred in finding this case distinguishable from Albee v. SAIF, 45 Or App 1027 (1980). In that case, the court held that an injury sustained while the claimant was on his way to put tire chains on his car occurred outside the scope and course of his employment. Because the Court of Appeals has remanded this case to us solely to consider whether claimant's injury "arose out of" his employment, we need not address Albee at this juncture. However, even if we were required to do so, we would continue to adhere to the reasoning in our prior order.

Board Chair Neidig dissenting.

Inasmuch as I am not persuaded that claimant has satisfied the requisite causal connection between his injuries from the falling flower box and his employment, I would conclude that his injuries did not arise out of his employment. Consequently, I respectfully dissent.

In order to fully evaluate the "arising out of" portion of the work-connection test, I submit that the Board's focus must be on all of the circumstances surrounding the traumatic event. The majority limits its attention to the flower box, reasoning that its very existence created a "hazard" on the employer's premises. Unlike the icy pavement or the rough driveway which were present in the Malinen and Nelson decisions, I submit that a stable flower box (but for being struck by a vehicle) does not constitute a "hazard" associated with claimant's employer's parking lot.

I believe that our analysis must extend to the activity which caused the flower box to fall. In doing so, I do not apply a "negligence" standard as is suggested by the majority. Rather, I merely examine the evidence to determine whether that activity was causally connected to claimant's employment.

Here, the evidence is uncontroverted that the falling flower box was caused by claimant's supervisor's wife's car striking the box. The car was being moved closer to claimant's truck in an effort to attach jumper cables to the vehicles to re-start claimant's truck. Thus, the activity that caused the falling flower box (the dead battery in claimant's truck) has nothing to do with claimant's employment. Instead, the "jump starting" activity was entirely attributable to claimant's personal needs. In light of such circumstances, I find the causal connection between claimant's injuries and his employment to be tenuous at best and insufficient to establish that his injuries "arose out of" his employment.

Had there been no outside force dislodging the flower box or had the box collapsed while claimant was leaning on the structure, I would be more inclined to find a sufficient causal connection between claimant's injuries and his employment. Such circumstances would lend credence to a conclusion that the flower box constituted a "hazard" on the employer's parking lot. However, because the falling flower box was triggered by an "outside force" and since the activity which prompted that "force" had no connection to claimant's employment, I cannot share my fellow members' conclusion that claimant's injuries "arose out of" his employment.

For analytical purposes, I see this situation essentially no differently than I would see the following scenarios. Claimant is directly struck by his supervisor's wife's car while she is attempting to move closer to "jump start" claimant's truck. Claimant is injured while attempting to attach the "jumper cables" between the two vehicles.

As with the present case, each of these injuries would be attributable to actions which were solely designed to accomplish a personal purpose; i.e., re-start claimant's truck so he could drive his vehicle home at the end of his work day. The present situation adds an employer-created structure to the fact pattern. Nevertheless, I submit that the essential analysis remains unchanged. That analysis is as follows.

One, what caused claimant's injuries? A falling flower box. Two, why did the flower box fall? Claimant's supervisor's wife's car hit it. Three, why did the car hit the flower box? The supervisor's wife was trying to get closer to claimant's truck so they could "jump start" claimant's dead battery so he could go home after the end of his work day. The answers to each of these inquiries leads one to the inescapable conclusion that there was no causal connection between claimant's injuries and his employment conditions.

Based on the aforementioned reasoning, I would find that claimant's injury claim is not compensable. Therefore, I respectfully dissent from the majority's decision to affirm the Referee's order.

August 26, 1994 Cite as 46 Van Natta 1694 (1994)

In the Matter of the Compensation of
GARY L. BEST, Claimant
WCB Case No. 93-05288
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of Referee Nichols' order that: (1) concluded that the SAIF Corporation properly accepted claimant's osteomylitis condition as a "resolved" condition; (2) declined to award claimant's counsel an assessed fee for allegedly prevailing over SAIF's "de facto" denial of his claim for chronic osteomyelitis, right knee arthritis and a lung condition; and (3) declined to assess penalties or related attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are scope of acceptance, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained multiple compensable injuries on December 10, 1986, as a result of a truck accident. Among his injuries were a lung contusion and a fractured right tibia. A formal notice of claim acceptance was issued on December 29, 1986, but did not list accepted conditions due to a clerical error. Claimant subsequently developed osteomylitis of the right leg and post-traumatic arthritis of the right knee.

Claimant requested a hearing on May 5, 1993, regarding "de facto" denial of chronic osteomylitis and post-traumatic arthritis of the right knee. SAIF then issued two notices of claim acceptance on June 10, 1993 and July 12, 1993, which formally accepted several conditions, among which were claimant's osteomylitis and post-traumatic arthritis. The osteomylitis of claimant's right tibia was specifically accepted as "resolved" in the June 10, 1993 acceptance notice.

A Determination Order then issued on June 16, 1993, which awarded 37 percent scheduled permanent disability for loss of use or function of claimant's right leg. Fifteen percent of this award was based on "healed avascular necrosis of tibia." (Ex. 108-2).

At the August 3, 1993 hearing, claimant raised the additional issue of "de facto" denial of a contused/collapsed lung. The claims examiner testified that there had been no denials issued in the claim and that all medical bills had been paid. All conditions had been treated as if accepted, with the lung condition considered incorporated into the original acceptance. Claimant testified that he was unaware of any outstanding medical bills. To his knowledge, he had not been denied any compensation.

Claimant asserted that his osteomylitis had been incorrectly accepted as "resolved." Claimant also contended that his lung condition should have been accepted and, because it was not, it was denied "de facto." Arguing that he was instrumental in obtaining compensation for claimant without a hearing, claimant's attorney also alleged entitlement to an attorney fee under ORS 656.386(1) because SAIF accepted his osteomylitis and arthritis conditions after he filed a request for hearing. Claimant's attorney also requested an attorney fee pursuant to that statute for obtaining rescission of an alleged "de facto" denial of claimant's lung condition. Finally, claimant asserted entitlement to penalties and attorney fees under ORS 656.262(10) and ORS 656.382(1) for unreasonable claim processing.

The Referee determined that claimant's osteomylitis condition was properly accepted as "resolved." The Referee also reasoned that, notwithstanding its failure to accept or deny the lung condition, the compensability of that condition was never contested by SAIF. Therefore, the Referee concluded that there had been no "de facto" denial of claimant's lung condition. See Lisa A. Hyman, 44 Van Natta 2516 (1992). Finally, the Referee also found that SAIF's claims processing was not unreasonable and that claimant's counsel was not entitled to an attorney fee under ORS 656.386(1) because claimant failed to show that additional compensation had been obtained.

We adopt the Referee's reasoning and conclusions with the exception of that pertaining to the scope of acceptance of claimant's osteomyelitis condition and to claimant's counsel's entitlement to an assessed attorney fee pursuant to ORS 656.386(1) for obtaining rescission of an alleged "de facto" denial of claimant's osteomylitis and post-traumatic arthritis conditions. We agree with claimant that SAIF improperly accepted his osteomyelitis condition as "resolved." We also find that claimant's counsel is entitled to an assessed attorney fee under ORS 656.386(1).

Scope of Acceptance

As previously noted, SAIF accepted claimant's right tibia osteomylitis as "resolved." While SAIF asserts that it used that adjective based on diagnostic testing that showed no radiographic evidence of osteomyelitis, and that it was not intending to deny claimant's condition, we agree with claimant that a notice of acceptance should not address permanency of an accepted condition. We reach this conclusion because of the procedural problems that such an acceptance can cause.

First, accepting a condition as "resolved" necessarily implies that the carrier believes that it is no longer responsible for benefits since the accepted condition no longer exists. Such an acceptance can be construed as both an acceptance and a prohibited preclosure partial denial. See Safstrom v. Riedel International, 65 Or App 728 (1983), rev den 297 Or 124 (1984); Roller v. Weyerhaeuser, 67 Or App 583, mod 68 Or App 743, rev den 297 Or 124 (1984). Inasmuch as claimant's claim was closed almost simultaneously with the acceptance of the allegedly "resolved" osteomyelitis condition, and since that closure resulted in a permanent disability award, we do not find that SAIF was attempting to circumvent the claim closure provisions of ORS 656.268 through its "denial" of claimant's osteomyelitis condition. However, SAIF's use of the word "resolved" raises another claim processing violation.

A carrier may deny a specific unpaid claim or a current claimed need for treatment, but may not deny its future responsibility relating to an accepted claim. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). This is precisely what SAIF has attempted to do in this claim when it accepted claimant's osteomyelitis condition as "resolved." While claimant received an award of permanent disability for his right leg, including an allocation of permanent impairment for his right tibia, SAIF's acceptance of the osteomyelitis condition as "resolved" also implies that it is denying responsibility for future benefits for the compensable condition. Such a denial is invalid and of no effect since it attempts to deny future benefits resulting from the injury that gave rise to the accepted claim. Boise Cascade Corp. v. Hasslen, 108 Or App 605, 607 (1991).

Consequently, we set aside that portion of SAIF's acceptance which limited its responsibility to a "resolved" osteomyelitis condition on the grounds that it is a prohibited prospective denial of future benefits for the compensable condition. Evanite Fiber Corp. v. Striplin, supra.

The dissent argues that the wording of SAIF's acceptance should not be construed as a "prospective" denial because claimant has received an award of permanent disability and there is no evidence that compensation has been withheld from claimant. However, the fact that all compensation has been paid at the present time does not mean that SAIF will continue to do so in the future. It is claimant's continued entitlement to benefits related to the accepted condition that the Striplin rationale is intended to govern. Inasmuch as SAIF's limited acceptance of claimant's osteomylitis condition places claimant's future compensation at risk, it is a prohibited prospective denial under Striplin.

Given our conclusion, claimant's counsel is entitled to an attorney fee for his efforts on this issue both before the Referee and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review regarding the prospective denial is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORS 656.386(1) Attorney Fee

Whether acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449, 454 (1992). Mere payment of benefits does not constitute acceptance. ORS 656.262(9). Although SAIF paid all compensation, it did not accept claimant's osteomylitis and post-traumatic arthritis conditions until after claimant's counsel filed a hearing request. This acceptance did not occur until more than 90 days after SAIF had notice or knowledge of these conditions. Therefore, we find that a "de facto" denial occurred. Safeway Stores, Inc., v. Smith, 117 Or App 224 (1992); Barr v. EBI Companies, 88 Or App 132, 134 (1987).

We emphasize that a claimant's rights to benefits under the workers' compensation system have not been secured until acceptance of the claim. Therefore, a claimant's attorney who obtains acceptance of a claim through filing a hearing request is instrumental in obtaining compensation without a hearing, even though all benefits have been paid. See Euzella Smith, 44 Van Natta 778, 780 (1992). Under these circumstances, we also find that claimant's counsel is entitled to an assessed fee under ORS 656.386(1). See Nancy S. Jenks, 46 Van Natta 1441 (1994); Barbara J. Fuller, 46 Van Natta 1129 (1994); Wesley R. Craddock, 46 Van Natta 713 (1994).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services in obtaining rescission of the "de facto" denial is $150, to be paid by SAIF. In reaching this conclusion, we have particularly considered those services leading to SAIF's acceptance of the omitted conditions (based on the record), the complexity of the issues, the value of the interest involved and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated August 26, 1993 is reversed in part and affirmed in part. Those portions which approved the wording of SAIF's acceptance and declined to award claimant an assessed attorney fee under ORS 656.386(1) are reversed. SAIF's acceptance of claimant's osteomylitis condition is clarified to eliminate the word "resolved." Claimant's attorney is awarded an assessed attorney fee of

$500 for his efforts in clarifying SAIF's acceptance. Claimant's counsel is also awarded an assessed fee of $150 for his efforts in prompting the "pre-hearing" rescission of SAIF's "de facto" denial of his osteomylitis condition. Both awards are payable by SAIF. The remainder of the Referee's order is affirmed.

Board Member Haynes concurring in part and dissenting in part.

Although I agree that claimant's counsel is entitled to an assessed fee under ORS 656.386(1) for obtaining rescission of a "de facto" denial, the majority errs, however, in awarding an assessed fee under that statute for removing the word "resolved" from SAIF's acceptance. Inasmuch as I do not believe that SAIF's acceptance of a "resolved" osteomylitis condition should be construed as a prospective denial, I dissent.

The majority finds that SAIF's acceptance of a "resolved" condition necessarily implies that it is denying future benefits. Such an inference is completely unwarranted. There is no evidence that SAIF has intended to deny any benefits. In fact, all the evidence is to the contrary.

The majority recites the claims examiner's testimony that all of claimant's medical conditions have been treated as accepted. Even claimant concedes that there are no outstanding medical bills and that he has not been denied compensation. SAIF even provided home health care for claimant's osteomylitis condition. In addition, even after SAIF issued its alleged "prospective" denial, it paid 37 percent permanent disability for claimant's right leg, including 15 percent allocated for claimant's right tibia.

Given SAIF's conduct, I am very puzzled by the majority's conclusion that SAIF issued a prospective denial when it accepted claimant's osteomylitis as "resolved." It seems quite clear that SAIF was merely using terminology that carriers frequently use when the medical evidence at the time of acceptance indicates that the compensable condition is not active. Use of the word "resolved" is by no means a definitive statement by a carrier, equivalent to a denial, that the compensable condition will never result in future medical treatment or disability or that it will refuse to pay benefits in the future.

In conclusion, the majority reads far too much into the wording of SAIF's acceptance, especially in light of the uncontroverted evidence that SAIF has never denied, or intended to deny, claimant benefits for his compensable osteomylitis condition. For this reason, I must respectfully dissent from the majority's opinion relative to the scope of SAIF's acceptance.

August 26, 1994 Cite as 46 Van Natta 1697 (1994)

In the Matter of the Compensation of
ELIZABETH BROSIUS, Claimant
WCB Case No. 94-04305
ORDER DENYING MOTION TO DISMISS
Parker, Bush & Lane, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Claimant has moved to dismiss the insurer's request for Board review of the Referee's order on the ground that the request fails to comply with OAR 438-11-005(4) in that the request does not recite whether or not payment of compensation will be stayed under ORS 656.313. The motion is denied.

FINDINGS OF FACT

On July 20, 1994, the Referee issued an Opinion and Order. Pursuant to that order, the Referee: (1) set aside the insurer's denial insofar as it pertained to claimant's left rotator cuff tear; (2) awarded an insurer-paid attorney fee under ORS 656.386(1); (3) declined to assess a penalty for an allegedly unreasonable denial; and (4) assessed a penalty for a discovery violation.

On August 5, 1994, the Board received the insurer's request for Board review of the Referee's order. The request stated that payment of compensation "may be stayed under ORS 656.313."

CONCLUSIONS OF LAW

Pursuant to ORS 656.313(1)(a), filing by an employer or the insurer of a request for Board review stays payment of the compensation appealed, except for: (A) temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is reversed, whichever event first occurs; or (B) permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed. The Board shall expedite review of appeals in which payment of compensation has been stayed under ORS 656.313(1). ORS 656.313(1)(b). Pursuant to OAR 438-11-005(4), a request for Board review should also recite whether payment of compensation will be stayed under ORS 656.313.

Here, claimant asserts that the insurer's request should be dismissed because it "dodges the requirement for information listed in OAR 438-11-005(4)" in that the request does not definitively state whether payment of compensation will be stayed under ORS 656.313 pending Board review of the Referee's order. We deny claimant's motion to dismiss the insurer's request for Board review.

We agree with claimant's assessment that the insurer's request neglects to answer the pivotal question posed by OAR 438-11-005(4) in that the request does not state whether or not compensation will be stayed. Compliance with the rule is strongly encouraged because such notification further assists the Board in identifying cases which are subject to expedited review under ORS 656.313(1)(b) and OAR 438-11-022. Nevertheless, such noncompliance with the aforementioned rule does not result in dismissal of the insurer's request for review. We have previously held that, since OAR 438-11-005(4) is not jurisdictional but rather an informational aid, we lack authority to dismiss a timely filed request for Board review based on a carrier's failure to strictly comply with a procedural rule. Leslie Thomas, 43 Van Natta 1364 (1991).

In the event we denied the motion to dismiss, claimant alternatively seeks expedited review under ORS 656.313(1)(b). Inasmuch as the Referee's order set aside the insurer's denial of claimant's left rotator cuff tear and remanded the claim to the insurer for acceptance and processing according to law and since the insurer's request stated that "compensation may be stayed," we conclude that this case is subject to expedited review. ORS 656.313(1)(b); OAR 438-11-022.

Accordingly, upon receipt of a transcript, copies will be provided to the parties and a briefing schedule implemented. After completion of the briefing schedule, this case shall be docketed for review.

IT IS SO ORDERED.

August 26, 1994 Cite as 46 Van Natta 1698 (1994)

In the Matter of the Compensation of
LYNNE C. GIBBONS, Claimant
WCB Case No. 92-12394
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig, Westerband, and Gunn.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of claimant's hepatitis type C claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Except for a period of time in 1991, claimant has worked as a dialysis technician since 1975. She worked in such a capacity for the insured's employer from November 1991 to June 1992.

In June 1992, claimant was diagnosed with hepatitis type C. Claimant asserts that the condition is compensably related to her work as a dialysis technician because blood from patients using the dialysis equipment occasionally splashed on her skin and clothing.

The record contains numerous opinions regarding causation. Dr. Lobitz, claimant's treating gastroenterologist, first reported that, because claimant tested positive for hepatitis type C antibodies in June 1992 and such results generally occurred several weeks to a month after the onset of acute hepatitis type C, exposure to hepatitis type C occurred before her illness in June 1992. (Ex. 19-2). Dr. Lobitz further stated that the most common exposure to hepatitis type C is from blood, such as transfusions and IV drug use; because claimant did not have a history of blood transfusions or IV drug use, Dr. Lobitz indicated that her "greatest risk for exposure" was her work as a dialysis technician, although he further noted that it was "impossible to know when that exposure might have occurred." (Id. at 3).

Dr. Lobitz subsequently concurred with a "check-the-box" report authored by claimant's attorney stating that claimant's work as a dialysis technician was her "highest risk factor" and that "work activities were the major exposure causing hepatitis[.]" (Ex. 29-2).

Dr. Benner, associate professor of medicine at OHSU, examined claimant at Dr. Lobitz's referral. He diagnosed chronic hepatitis type C, noting that apparently claimant contracted the condition several months before the onset of symptoms in June 1992 and that the "most likely exposure is related to her work as a dialysis technician[.]" (Ex. 29A-3).

Dr. Fuchs, pathologist, reviewed the medical records at the insurer's request. According to his report and testimony at hearing, Dr. Fuchs agreed that claimant had hepatitis type C but was unable to determine if the condition was work-related. (Ex. 18, Tr. 81). Dr. Fuchs indicated that hepatitis type C could be transmitted from exposure to blood from an infected person; however, he found the risk of such an occurrence in claimant's case to be "low" because she used safeguards, such as gloves and face shield, and had reported no "needle sticks." (Ex. 18-3, Tr. 87-88). Furthermore, he found that transmission from blood splashed on unprotected skin was "extremely unlikely." (Tr. 108).

Dr. Goodall, internal medicine and infectious diseases specialist, also reviewed the medical record on behalf of the insurer. He reported that, in comparison to other potential causes of hepatitis type C, claimant's employment as a dialysis technician was "probably the highest risk for contracting" the disease. (Ex. 20). However, Dr. Goodall found it "unlikely" that claimant's condition was work-related because she had not experienced a "needle stick" and it was not possible to know when she contracted the infection. (Ex. 20, Tr. 110, 114, 118). He also indicated that intact skin was an effective barrier to the transmission of the disease. (Tr. 124).

In order to prevail, claimant must show that employment conditions are the major contributing cause of her hepatitis type C condition. See ORS 656.802(2). The only medical opinion providing such a causal link is the "check-the-box" report from Dr. Lobitz. However, because his previous reports and the opinions of other physicians at most indicate only that claimant's work was the highest risk factor, we do not find the report persuasive.

Claimant contends she has met her burden by showing that "her working environment placed her at an increased risk of contracting the disease." Even if we assume that the medical evidence made such a showing, we find that it is insufficient to establish compensability. Based on ORS 656.266, a claimant must show that a condition is in fact related to the work environment. See Ruben G. Rothe, 45 Van Natta 369 (1993); Tamara D. Hergert, 45 Van Natta 177 (1993). Therefore, in the absence of medical evidence which would support a finding that claimant was exposed to hepatitis type C during the course of her work as a dialysis technician, we are unable to find the requisite causal connection.

ORDER

The Referee's order dated October 5, 1993 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that claimant failed to prove the compensability of her hepatitis type C condition. Claimant's work as a dialysis technician exposed her to persons infected with hepatitis type C. In particular, during the course of her work, claimant was subjected to blood splashes on her skin and clothing. Not surprisingly, the medical opinions overwhelmingly show that claimant's work as a dialysis technician constituted the greatest risk for contracting her disease.

I disagree with the majority that Dr. Lobitz's reports were inconsistent because he first stated that claimant's work provided the highest risk for becoming infected and then indicated that claimant's employment was the major contributing cause of her condition. I find that such reports indicate that Dr. Lobitz was of the opinion that claimant's employment was the major contributing cause because it was the highest risk factor. If Dr. Lobitz, who specializes in the treatment of infectious diseases, is able to reach such a conclusion, I do not understand the majority's position to the contrary.

As the medical evidence shows, claimant is in a "high risk" occupation in that the likelihood of exposure to toxic substances is much greater is comparison to that of the general population. Therefore, claimant need not establish a particular incident of exposure to hepatitis type C. In other words, like those cases concerning exposure to asbestos, claimant need only show that the working environment has a toxin; claimant was exposed to such substance; and there is evidence that exposure was the major contributing cause of the occupational disease.

Claimant showed that, because she was exposed to blood during her work, her employment was the greatest risk for contracting hepatitis type C. Furthermore, there was medical opinion that her work was the major contributing cause of her infection. Claimant3could do no more to prove the compensability of her condition. Because I would conclude that claimant established compensability, I dissent.

In the Matter of the Compensation of
DEANA I. LEIGHTY, Claimant
WCB Case No. 93-04773
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee McCullough's order that upheld the SAIF Corporation's denial of her claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last two paragraphs.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her low back in May 1983 and underwent surgery in October 1983. Claimant was awarded 35 percent unscheduled permanent partial disability pursuant to a Stipulation and Order dated August 23, 1984. (Ex. 14). From mid-1984 to late 1989, claimant saw Dr. Gallagher intermittently for low back pain and her subsequent treatment has been conservative. (Ex. 4). Between November 1989 and December 1992, claimant did not receive medical services from Dr. Gallagher for her low back. In late November 1992, claimant began experiencing gradually worsening low back pain. (Tr. 10-11). On December 8, 1992, claimant experienced increased low back pain with radiation into her buttocks and legs when she was bending over at work. (Tr. 15-16).

Since her five-year aggravation rights had expired, claimant sought reopening of her claim pursuant to ORS 656.278(1). However, Own Motion relief was denied because claimant had not required surgery or hospitalization for treatment. (Ex. 27).

Thereafter, claimant requested a hearing from SAIF's "new injury/occupational disease" denial. Although we agree with the Referee that claimant failed to prove compensability of her current condition, we affirm the Referee's order based on the following reasoning.

We find that the claim should be analyzed as an injury rather than an occupational disease. The injury was unexpected, as claimant's back had been asymptomatic since late 1989. (Ex. 4). See Valtinson v. SAIF, 56 Or App 184, 188 (1982). Moreover, her injury was "sudden in onset" in that it occurred over a discrete, identifiable period of time. See id. The fact that claimant's pain grew progressively worse over a short period of time does not make it "gradual in onset." Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984).

The issue is whether the claim is properly processed as an aggravation or a "new injury." In David L. Large, 46 Van Natta 96 (1994), we concluded that, in cases involving the same employer/insurer, we would continue to conform the test for distinguishing new injuries from aggravations with current responsibility law. Subsequent to the Referee's order, the Supreme Court ruled that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). SAIF v. Drews, 318 Or 1 (1993). Thus, claimant sustained a "new injury" for claim processing purposes if the December 1992 incident is the "major contributing cause" of her treatment.

Here, because of the passage of time since claimant's initial low back injury, the causation issue is a complex medical question that must be resolved by expert evidence. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

Dr. Brown, a neurologist, and Dr. Fuller, an orthopedic surgeon, examined claimant on behalf of SAIF in February 1993 and reported that the major contributing cause of her current condition was the surgery she had in 1983 and the residual back discomfort she has had since that time. (Ex. 22). Drs. Brown and Fuller concluded that there had been no worsening of her residual back condition resulting from the December 8, 1992 incident and that the new incident represented normal waxing and waning of her 1983 injury. (Id.)

Dr. Gallagher, claimant's treating physician, examined claimant after the December 8, 1992 incident and reported an "[a]ggravation of chronic low back pain." (Ex. 4). In a January 1993 letter to SAIF, Dr. Gallagher stated that "this present episode is an aggravation of her previous chronic, low back problem" and that the new incident did not permanently worsen her condition but did increase her symptoms. (Ex. 20). Dr. Gallagher's February 25, 1993 chart notes reflect that he agreed with the findings of Drs. Brown and Fuller, "stating that [claimant] is back to her preinjury status and had had no worsening of her condition." (Exs. 4 & 23). Dr. Gallagher reported to SAIF in April 1993 that the new incident "was an aggravation of [claimant's] chronic low back condition which already is an accepted claim by SAIF." (Ex. 29).

Claimant relies on Dr. Gallagher's July 1993 "concurrence letter" from claimant's attorney to demonstrate that she has proved a worsening of her condition. In that letter, Dr. Gallagher agreed with the following:

> "Although [claimant] has had chronic back difficulties prior to these more recent work activities, it is clear that this type of work activity has aggravated her preexisting low back condition. It would be your opinion, in terms of reasonable medical probability, therefore, that the recent work activities that [claimant] has performed, which clearly exceed the recommended restrictions, have caused a material worsening of her underlying, preexisting back condition. These activities constitute the major contributing cause of a worsening of [claimant's] preexisting back condition. Fortunately, the worsening was only temporary in nature; however, this is most accurately described as a new injury superimposed upon a preexisting, chronic back condition." (Ex. 31).

Dr. Gallagher's previous reports indicated that he believed the December 1992 incident was an aggravation of claimant's 1983 injury and that the new incident did not worsen her condition. Assuming that Dr. Gallagher's July 1993 concurrence is a statement that claimant suffered an actual worsening of her underlying condition, we do not find it persuasive because he did not offer a reasonable explanation for his change of opinion. See Kelso v. City of Salem, 87 Or App 630 (1987).

We are unable to find persuasive medical evidence that establishes that the December 1992 incident was the major contributing cause of claimant's current condition. Therefore, we conclude that claimant's current back condition was a continuation of her 1983 compensable injury rather than a new injury. Inasmuch as claimant has not established a new compensable injury, we conclude that SAIF's denial must be upheld.

ORDER

The Referee's order dated August 17, 1993 is affirmed.

In the Matter of the Compensation of
RONALD L. LIGGETT, Claimant
WCB Case No. 93-12209
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Referee Emerson's order that increased claimant's scheduled permanent disability award for a right knee condition from 12 percent (18 degrees), as awarded by an Order on Reconsideration, to 16 percent (24 degrees). On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and opinion, except for the clause, "including his demonstration of movements required in his work," in the second full paragraph on page 2 of the order, and the sentence reading, "Adding to that the inability to do a full squat or to support kneeling weight on the right knee clearly entitle claimant to the increased award", in the last paragraph on page two of the order.[1] Additionally, we offer the following supplementation.

The employer argues that the Referee erred in finding that, based on a medical arbiter's report, claimant had established his entitlement to an additional award of scheduled permanent disability for loss of repetitive use of his right knee. Particularly, the employer argues that the Referee should have relied on the reports of Dr. Whitney, treating physician, which, according to the employer, support no chronic condition award. We disagree.

OAR 436-35-007(9) provides, in part, that "[o]n reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where the preponderance of the medical opinion establishes a different level of impairment."

On September 13, 1993, Dr. Smith, medical arbiter, noted that claimant reported that side-to-side stepping (which claimant was required to do at work) caused him considerable anteromedial right knee pain. (Ex. 16-2). Claimant also reported that squatting can cause popping in the knee, as well as pain. (Id.) On examination, Dr. Smith reported that "[t]ibial rotation tests in external rotation as well as McMurray tests in external rotation cause moderate anteromedial knee pain while these tests are normal on internal rotation." (Id.) On the basis of these findings, Dr. Smith concluded that claimant "is limited in repetitive squatting as well as in any activities which subject the knee to an external rotation stress." (Id. at 3).

Earlier, in February 1993, Dr. Whitney had noted that claimant's "McMurray's testing is unremarkable but stressing it does cause pain, and compression of the medial joint space." (Ex. 12-1). In March 1993, Whitney reported that claimant's McMurray's testing was "unremarkable." (Id. at 2). In April 1993, Dr. Whitney found that, although claimant still had occasional irritation of the medial aspect of his right knee on twisting or other movement, claimant could squat without difficulty; at that time, Whitney declared claimant medically stationary with no limitations. (Id.)

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[1] We decline to adopt the Referee's conclusion regarding his observations of claimant's demonstration at hearing concerning his work activities, because those observations may have had some bearing on the Referee's ultimate conclusion regarding claimant's impairment. See Torry R. Culp, 43 Van Natta 1811 (1991) (referee may not rate claimant's impairment based on personal observation of claimant's abilities at hearing). We also decline to adopt the Referee's conclusion regarding claimant's inability to do a full squat and to support kneeling weight on his right knee, because it appears that that conclusion is based solely on claimant's testimony. (See Tr. 8). See William K. Nesvold, 43 Van Natta 2767 (1991) (lay testimony insufficient to establish impairment). Notwithstanding our refusal to adopt these conclusions, for the reasons set forth in this order, we conclude the remaining evidence in the record establishes claimant's entitlement to the additional permanent disability awarded by the Referee.

On this record, we conclude that Dr. Whitney's opinions are not sufficient to establish a level of impairment different than that found by the medical arbiter, Dr. Smith. Although Whitney performed McMurray's testing, he made no specific findings with respect to external rotation. Furthermore, Dr. Whitney's February 1993 findings appear to be internally inconsistent: Although he found that the McMurray's testing was "unremarkable", he reported that "stressing it does cause pain." (Ex. 12-1). In light of those factors, we conclude that Dr. Whitney's reports are insufficient to overcome the persuasive and well-reasoned opinion of the medical arbiter. OAR 436-35-007(9).

Finally, the employer argues that, under Kathleen L. Hofrichter, 45 Van Natta 2368 (1993), Dr. Smith's recommendation that claimant avoid certain repetitive motions is insufficient to establish a permanent and chronic impairment. The employer's reliance on Hofrichter is misplaced. Dr. Smith did not recommend that claimant avoid repetitive knee motions; he concluded that claimant "is limited in repetitive squatting as well as in any activities which subject the knee to external rotation stress." (Ex. 16-3). We read Smith's opinion to mean that claimant is unable to perform repetitive activities that involve external rotation of the right knee, including squatting. (Ex. 16-3). Because that opinion is sufficient to establish that claimant is unable to repetitively use his right knee due to a chronic and permanent medical condition, OAR 436-35-010(6), we reject the employer's argument.

For these reasons, we agree with the Referee that claimant has established his entitlement to an additional permanent disability award for a right knee chronic condition.

Claimant is entitled to an assessed attorney fee for services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 25, 1994, as amended March 2, 1994, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
WILLIAM A. MARTIN, Claimant
WCB Case Nos. 94-02173 & 94-01987
ORDER ON REVIEW
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Referee Thye's order that dismissed his request for hearing. On review, the issue is the propriety of Referee's dismissal. We affirm.

FINDINGS OF FACT

On August 23, 1993, claimant signed a retainer agreement employing his then attorney of record to represent him in connection with his workers' compensation claim.

On February 4, 1994, claimant, through his then attorney of record, referenced a January 31, 1986 date of injury and requested a hearing raising, among other issues, the issue of the SAIF Corporation's "de facto" denial of a request for surgery. (WCB Case No. 94-01987).

On February 7, 1994, claimant, through his then attorney of record, referenced a January 5, 1994 date of injury and requested a hearing from SAIF's January 27, 1994 denial of his injury claim. (WCB Case No. 94-02173). Claimant's then-attorney requested that the two requests for hearing be consolidated.

A hearing was scheduled for May 4, 1994. On May 3, 1994, the Referee was notified by claimant's then-attorney's firm that the hearing request was being withdrawn. On May 5, 1994, the Referee dismissed claimant's hearing request.

By letter dated May 25, 1994, claimant notified the Board that he was no longer represented by an attorney and requested Board review of the Referee's order, noting that he was dissatisfied with the dismissal of his hearing request.

By letter dated May 31, 1994, claimant's former attorney notified the Board that his firm no longer represents claimant.

In a letter/appellant brief dated June 13, 1994, claimant acknowledged that he was represented by his then-attorney when the attorney requested that claimant's hearing request be withdrawn.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's hearing request. Claimant requests that the case be remanded to the Referee for a hearing. Under the circumstances of this case, we deny claimant's request for remand and affirm the Referee's dismissal order.

The issue before us is whether claimant's hearing request should have been dismissed. We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Where a Referee has dismissed a claimant's request for hearing and the record does not contain any motions, correspondence, records of telephonic conversations, testimony, or exhibits concerning the dismissal of claimant's hearing request, we have found the record incompletely and insufficiently developed. Tamara Riddle, 41 Van Natta 971 (1989); Robert J. Buckley, 41 Van Natta 1761 (1989); Donald R. Roth, 42 Van Natta 1091 (1990). Under those circumstances, we have remanded the matter to the Referee with instructions to conduct further proceedings to determine whether the dismissal was justified. If, after those further proceedings, the Referee determined that the dismissal was justified, we instructed the Referee to issue a final order setting forth his or her reasoning. On the other hand, if the Referee determined that the hearing request should not have been dismissed, we instructed the Referee that the matter should proceed to hearing on the merits raised in the claimant's hearing request, with the Referee issuing a final order upon closure of the hearing record. Id.

Here, the record regarding the request for dismissal essentially consists of a May 3, 1994 phone message from claimant's then-attorney's firm to the Referee noting that the hearing request was withdrawn. Thus, in contrast to the records in Riddle, supra, Buckley, supra, and Roth, supra, the record in the present case contains some evidence regarding the request for dismissal. More importantly, here, claimant acknowledges that he was represented at the time in question and that, while represented, his then-attorney requested that claimant's hearing request be withdrawn. (See claimant's letter/brief dated June 13, 1994).

We find that the record and claimant's concessions establish that claimant, through his then-attorney, withdrew his request for hearing. Claimant does not dispute his then-attorney's authority to act on his behalf, nor does he dispute the fact that the Referee dismissed his request for hearing in response to his then-attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the dismissal order.[1] Henry B. Scott, 45 Van Natta 2392 (1993); Mike D. Sullivan, 45 Van Natta 900 (1993); Eul G. Moody, 45 Van Natta 835 (1993).

ORDER

The Referee's order dated May 5, 1994 is affirmed.

[1] Member Gunn would point out to claimant that by the retainer agreement between claimant and his attorney, the attorney is authorized to act on claimant's behalf. If claimant is dissatisfied with his attorney's actions, his dispute is with the Professional Liability Fund of the Oregon State Bar, not this legal forum.

In the Matter of the Compensation of
CHARLENE C. MOYES, Claimant
WCB Case No. 93-04088
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Gunn.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral thumb condition. On review, the issue is compensability.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated September 22, 1993, is affirmed.

Board Member Gunn dissenting.

I disagree with my colleagues' decision that claimant has not established an occupational disease claim for arthritis in both thumbs. Therefore, I dissent.

In order to prove an occupational disease claim, the claimant must prove that employment conditions were the major contributing cause of the disease or its worsening. ORS 656.802(2). As a general rule, a worsening of symptoms alone is not sufficient to prove an occupational disease. See Weller v. Union Carbide, 288 Or 27, 35 (1979). However, the courts have recognized an exception to this rule: If the medical evidence establishes that the manifested symptoms are the disease, a worsening of symptoms is sufficient to prove an occupational disease. See Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

The record shows that claimant had chronic laxity of the carpal metacarpal joints of both thumbs with early degenerative arthritis, which preexisted her employment. However, there is no indication that claimant had any thumb symptoms or required any thumb treatment prior to her employment. She then began working for the employer, performing intensive and repetitive activities with both hands and thumbs in fine motor tasks (e.g., gripping, grasping, pulling, pushing and twisting). As a result of those demanding work activities, claimant developed thumb symptoms requiring treatment, including surgery, for the first time.

The Referee (and the majority) found that work conditions were the major contributing cause of claimant's thumb symptoms and subsequent need for treatment. Yet, they upheld the denial of claimant's thumb claim, finding that work conditions were not the major contributing cause of the underlying arthritis or its worsening.

I find, however, that the thumb symptoms were the manifestation of the arthritis condition. That is, but for the symptoms, there would have been no "condition" requiring treatment. Indeed, claimant is only seeking compensation for the symptoms themselves, not the underlying arthritis. Thus, if work conditions caused the symptoms, the claim for treatment for those symptoms must be compensable. Alternatively, I would find that the manifestation of symptoms following claimant's work exposure shows that the underlying arthritis condition had worsened as a result of that exposure. Therefore, I would conclude that claimant has established a compensable occupational disease claim for the thumb condition requiring treatment.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
MARTHA V. SLATER, Claimant
WCB Case No. 93-10018
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Referee T. Lavere Johnson's order that: (1) set aside its partial denial of medication prescribed by claimant's treating physician; (2) assessed penalties for allegedly unreasonable claims processing; and (3) awarded a carrier-paid attorney fee under ORS 656.386(1). On review, the issues are medical services, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

First, we briefly summarize the pertinent facts. Claimant suffered a compensable injury to her neck, right shoulder and right arm on June 20, 1989. A Determination Order issued on December 9, 1991. Claimant received an award of 25 percent unscheduled permanent disability.

Following the December 1991 claim closure, claimant was treated for multiple pain complaints: first by Dr. Maloney, M.D., then by Dr. Mann, D.O. Both doctors prescribed medications to treat claimant's pain. Claimant paid for the medications and now seeks reimbursement from the insurer. Specifically, claimant has made a medical services claim for prescription medication (Lodine and Prozac) and "over-the-counter" medication (Zostrix). The insurer partially denied the claim, alleging that the aforementioned medicines are noncompensable palliative medical services. (Ex. 24).

Claimant requested a hearing, seeking payment of the bills, as well as penalties and attorney fees for unreasonable claims processing. The Referee found that the medications prescribed by claimant's attending physicians do not fall within the classification of noncompensable medical care and are, therefore, compensable. ORS 656.245(1)(b),(1)(c); OAR 436-10-005(31). We agree with the Referee's result, but offer the following reasoning.

Compensability of Prescription Medication

Claimant was initially treated by Dr. Maloney for pain complaints related to her 1989 compensable injury. (Ex. 25 at 18-20). At deposition, Dr. Maloney testified that she prescribed Lodine, an anti-inflammatory medication, and Zostrix, an "over-the-counter" analgesic cream. (Ex. 25-12). These medications were prescribed to relieve claimant's chronic muscle pain in the right side of her neck, her midback and her lumbogluteal region. (Ex. 25-16). Dr. Maloney explained that claimant's chronic pain in her shoulder and neck areas had "referred beyond its original boundaries" to involve mid- and low-back structures. (Ex. 25-19).

Accordingly, Dr. Maloney prescribed medication to lessen claimant's pain and improve the circulation to the muscle fibers at the sites of claimant's muscle pain. (Ex. 25-10). Moreover, Dr. Maloney prescribed medication to enable claimant to improve her strength, endurance and flexibility. Dr. Maloney reasoned that such treatment allowed patients to return to their normal activity levels more quickly by discouraging "splinting, guarding, or shortening of muscles" as a "reflex of response to pain." (Ex. 25-20). However, Dr. Maloney added that neither Lodine nor Zostrix would cure claimant's chronic muscle pain. (Ex. 25-14).

Claimant was subsequently referred to Dr. Mann for further evaluation. In addition to the Lodine and Zostrix, Dr. Mann prescribed Prozac in an attempt to raise claimant's pain threshold so that she could "function at a higher level." (Ex. 26-9). At deposition, Dr. Mann testified that he did not prescribe Prozac as a curative medication. (Ex. 26-10). Rather, he was concerned that claimant's "migrating symptoms" might be indicating a psychosomatic pain disorder. (Ex. 26-12). Dr. Mann discontinued claimant's prescription for Prozac after approximately two months without signs of improvement. (Ex. 26-9).

ORS 656.327(1)(a) provides for review by the Director of medical treatment that is "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services." The Court of Appeals has construed ORS 656.327(1)(a) to vest exclusive jurisdiction over a medical treatment dispute with the Director if a party or the Director "wishes" Director review. Meyers v. Darigold, Inc., 123 OR App 217, 221-22 (1993). According to the Meyers court, if no "wish" for review has been filed, jurisdiction remains with the Board. Id.

In Theodore v. Safeway Stores, Inc., 125 Or App 172, 176 (1993), the court agreed with the Board that a dispute concerning whether medical treatment was palliative or curative could fall within the Director's review authority under ORS 656.327. However, pursuant to Meyers, the court further found that, if no party "wished" Director review, the Hearings Division and the Board had jurisdiction over the matter. Id.

Here, no party has "wished" for Director review under ORS 656.327(1). Therefore, we have jurisdiction regarding the medical services dispute. Meyers v. Darigold, Inc., supra; Theodore v. Safeway Stores, Inc., supra. Next, we consider whether the disputed treatment is palliative or curative.

ORS 656.245(1) provides, in relevant part:

> "(1)(a) For every compensable injury, the insurer or self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability.
>
> "(b) Notwithstanding paragraph (a) of this subsection, after the worker has become medically stationary, palliative care is not compensable, except when provided to a worker who has been determined to have permanent total disability, when necessary to

> monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device. If the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment.
>
> * * * * *
>
> "(c) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. * * * * * ." (Emphasis supplied).

Compensable medical services continue throughout the injured worker's lifetime, so long as those services are materially related to the accepted condition. ORS 656.245(1)(c); Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993). Curative medical services are those services rendered to diagnose, heal or permanently alleviate or eliminate an undesirable medical condition. OAR 436-10-005(31). Conversely, palliative care means a medical service rendered to temporarily reduce or moderate the intensity of an otherwise stable medical condition. OAR 436-10-005(31).

Generally, once a worker is medically stationary, palliative medical care is no longer compensable, unless approved by the Director. ORS 656.245(1)(b). However, ORS 656.245(1)(b) provides three exceptions where palliative medical care is automatically compensable without Director approval: (1) when provided to a worker with permanent total disability; (2) when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition; and (3) to monitor a prosthetic device. Accordingly, we conclude that the statutory scheme identifies three categories of medical services: curative medical care, compensable palliative care, and palliative care that is not compensable without Director approval.

The prescribing doctors in this case characterize their treatment as noncurative. (Exs. 25-14, 26-10). Therefore, we conclude that claimant's medications cannot be considered compensable as curative medical services.

The insurer admits that prescriptions for palliative medications are compensable when required to maintain an injured worker in a medically stationary condition; however, it contends that this exception is not applicable in this case. (App. Br. at 5). Therefore, the issue before us is whether claimant's medications are compensable palliative care, or palliative care that is not compensable without Director approval. ORS 656.245(1)(b).

The insurer argues that there is no evidence that claimant's prescription medications were required to maintain her in a medically stationary condition. (App. Br. at 10). We disagree. Both Drs. Maloney and Mann agree that claimant's compensable chronic pain has spread beyond its original sites in the cervical and parascapular regions to involve her mid and low back as well. (Exs. 25-18, 26-12). Furthermore, both doctors opined that claimant's medications were necessary to arrest this process in order to increase claimant's "functionality" and return her to normal activity levels. (Exs. 25-20, 26-9).

We find that the statements made by Drs. Maloney and Mann support the conclusion that the prescribed medications were necessary to maintain claimant in a medically stationary condition. See generally, McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986) ("magic words" not essential where the medical opinions strongly support ultimate conclusion). Under these circumstances, we conclude that claimant's medications were prescribed to maintain claimant in a medically stationary condition.

Accordingly, we find that claimant's prescribed medications are properly classified as palliative care that is automatically compensable without Director approval. In other words, inasmuch as claimant's physicians prescribed the medications to maintain claimant in a medically stationary condition, those medications are compensable palliative care under ORS 656.245(1)(b).

We believe this interpretation of ORS 656.245 is consistent with the express language of the statute. See PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993) (The best evidence of legislative intent is reading the text of the statute in conjunction with relevant rules of construction). It would lead to absurd results were we to construe ORS 656.245(1)(b) to provide that, although the medical care necessary to monitor medication required to maintain a worker in a medically stationary condition is compensable, the medication necessitating the monitoring is noncompensable palliative care. We do not believe the legislature intended such an absurd result. See generally, Davies, Legislative Law and Purpose 297 (2d ed. 1986).

Therefore, we conclude that prescription medications necessary to maintain a worker in a medically stationary condition are compensable palliative care that does not require Director approval, as is the medical care necessary to monitor those medications. Accordingly, we conclude that, inasmuch as claimant's medications were prescribed to maintain her in a medically stationary condition, her palliative medical services claim is compensable without Director review. ORS 656.245(1)(b).

The insurer asserts that in Daniel K. Bevier, 46 Van Natta 41, on recon 46 Van Natta 215, 46 Van Natta 909 (1994), we erred by holding that "prescriptions for palliative medications are per se compensable." (App. Br. at 7). We disagree with the insurer's interpretation of our holding in Bevier.

In Daniel K. Bevier, supra, we found that the claimant's prescription medications could be classified as curative medical services, since they were provided to permanently alleviate an undesirable medical condition (incapacitating depression). Id. at 44. Here, however, we find that claimant's medications were prescribed to maintain claimant's condition in a medically stationary status, not to permanently alleviate her chronic condition.

However, in Bevier we also held, in the alternative, that to the extent that the prescription medications were necessary to maintain claimant in a medically stationary condition, they were compensable without prior approval by the Director. Id. at 44. Contrary to the insurer's arguments, we did not find palliative medications to be "per se" compensable. But, to the extent that medication is necessary to maintain an injured worker in a medically stationary condition after claim closure, those medical services are compensable under ORS 656.245(1)(b).

Finally, the insurer argues that neither Dr. Maloney nor Dr. Mann had the requisite status as an attending physician necessary to authorize medical services. (App. Br. at 12). We find no merit to this argument.

Claimant was declared medically stationary on September 13, 1991. (Ex. 17). The insurer formally denied claimant's request for medical services on August 13, 1993. (Ex. 24). At the time the denial issued, claimant had outstanding pharmacy charges of at least $298.69. (Ex. 23). The insurer does not dispute that these charges accrued over the intervening two years between claimant's medically stationary date and the insurer's denial. Both Drs. Maloney and Mann were claimant's authorized treating physicians during this period. (Ex. 20-1). Furthermore, the insurer's partial denial was based upon the compensability of the medical services requested, not the legal status of the prescribing doctors. (Ex. 24). Accordingly, we conclude that Drs. Maloney and Mann were authorized by statute to prescribe medical services for claimant, during the relevant time period. See ORS 656.245(3)(b)(A).

Penalties and Attorney Fees

With regard to the penalty issue, the insurer argues that the Referee erroneously relied on Department Bulletin No. 229 in finding that the insurer had unreasonably resisted reimbursing claimant for her medication expenses. (The Bulletin provided that prescription medications are required medical services pursuant to ORS 656.245(1)(a) and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-10-041.) The insurer contends that, as the Department Bulletin is neither a statute, nor an administrative rule, it has no force of law. We need not resolve the question of the viability of the Department's Bulletin because we conclude that, even in the absence of the Bulletin, the insurer did not have a legitimate doubt as to its liability for the medication. See Brown v. Argonaut Ins. Co., 92 Or App 588 (1988).

Specifically, the insurer concedes that if claimant's medications are materially related to her compensable injury and required to maintain her in a medically stationary condition, then those medications are compensable medical services under the palliative care exception of ORS 656.245(1)(b). We find that the insurer had no legitimate doubt that the requested medical services were related to claimant's June 1989 injury, and that they were necessary to maintain claimant in a medically stationary condition.

As discussed above, both Drs. Maloney and Mann opined that the medications were necessary to arrest claimant's "migrating symptoms," increase claimant's "functionality," and encourage a return to normal activity levels. (Exs. 25-12, 25-20, 26-9). These medical opinions are not rebutted. Therefore, we conclude that the insurer's denial of those medical services was unreasonable, and we affirm the Referee's assessment of a penalty and attorney fee under ORS 656.262(10).

Lastly, the insurer argues that the Referee erred in awarding an assessed attorney fee pursuant to ORS 656.386(1). The insurer asserts that, inasmuch as the only issue at hearing was the insurer's failure to reimburse claimant for her medications, the compensability of claimant's accepted injury was never at issue and, consequently, attorney fees could not be awarded under ORS 656.386(1). We disagree.

In accordance with our recent decision in Gwen A. Jackson, 46 Van Natta 357, on recon 46 Van Natta 822 (1994), we conclude that the insurer's partial denial of claimant's medical care, and its consequent refusal to reimburse claimant's expenses for her prescribed medication, constitutes a decision denying the claim for compensation. Daniel K. Bevier, supra, on recon 46 Van Natta at 910. Since claimant finally prevailed before the Referee over that denied medical services claim, we hold that she is entitled to an attorney fee award under ORS 656.386(1) for her counsel's services at hearing.

Furthermore, claimant is also entitled to an assessed attorney fee for prevailing over that portion of the insurer's request for review which pertains to the issue of the compensability of prescription medications. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on Board review concerning the medical services dispute is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated. We further note that claimant is not entitled to an attorney fee for services on review regarding the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated January 4, 1994, is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,200, payable by the insurer.

In the Matter of the Compensation of
MARKUS M. TIPLER, Claimant
WCB Case Nos. 93-00098, 93-02777, 92-12348 & 93-00997
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Dennis Martin (Saif), Defense Attorney
Cummins, Brown, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation, on behalf of Starfire Lumber Co. (Starfire), requests review of that portion of Referee Myzak's order which: (1) set aside its denial of claimant's aggravation claim for a right shoulder condition; and (2) upheld the SAIF Corporation's denial, on behalf of Surco Logging, Inc. (Surco), of claimant's new injury/occupational disease claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of her "Findings of Ultimate Fact." We also offer the following summary of the relevant background of this claim.

On April 24, 1989, claimant compensably injured his right shoulder when he pulled hard on a piece of timber while employed by Liberty's insured (Starfire). Claimant testified that he felt like he had separated his shoulder and that he had heard a "clunk." (Tr. 7). The injury was diagnosed and accepted as a right shoulder strain.

Claimant, on referral from Dr. Dreyer, his then-attending physician, consulted Dr. Carter, an orthopedic surgeon, on May 11, 1989. Dr. Carter specifically reported that he could detect no right shoulder instability. (Ex. 5-1). The claim was subsequently closed on August 1, 1989, with no award of permanent disability.

Subsequent medical treatment was primarily focused on compensable conditions apart from the right shoulder. Claimant testified that, during a one-year period in late 1989 and 1990, he had little, if any, problem with this right shoulder. (Trs. 10, 11). At this time, claimant attended truck driving school and later drove trucks for a lumber company (Square Deal), which the parties stipulated at hearing was not responsible for claimant's right shoulder condition.

In the summer of 1991, claimant began working as a truck driver for SAIF's insured (Surco). His work activities consisted of throwing "wrappers" weighing no more than 15 pounds underhanded over logs on his truck. Claimant would engage in this activity, which also involved securing the ends of the wrappers, normally eight times a day. (Tr. 15). There was no new traumatic incident while claimant was employed by Surco.

In March 1992, claimant returned to Dr. Dreyer, reporting severe pain in the posterior shoulder with tingling in the ulnar right hand and arm. In August 1992, claimant changed attending physicians to a family practitioner, Dr. Bocian. Dr. Bocian diagnosed deltoid bursitis and latissimus dorsi muscle strain of the right shoulder. Dr. Bocian treated claimant three times in the summer of 1992 and one time in July 1993. While he initially related claimant's right shoulder problems to the 1989 injury, Dr. Bocian, after reviewing Dr. Carter's May 1989 medical report and the February 1991 report of examining physicians, Drs. Baker and Brooks, concluded that claimant's current right shoulder condition was not related to the 1989 injury. (Ex. 52). Dr. Bocian opined that claimant's bursitis and muscle strain "could" result from his log-truck driving activities. (Ex. 52).

Claimant's current right shoulder condition has been evaluated by a number of examining physicians, including Drs. Neufeld and Wilson, on behalf of Liberty, and Drs. Baker and Barth, on behalf of SAIF. On December 12, 1992, Drs. Wilson and Neufeld diagnosed a "resolved" 1989 right shoulder strain and concluded that claimant's current right shoulder condition was not related to the original injury in 1989. (Ex. 44). They did not comment as to the impact, if any, of claimant's current work activities on his right shoulder condition. Their examination did not detect any instability in claimant's right shoulder.

On June 10, 1993, Drs. Baker and Barth concluded that claimant's current right shoulder condition was a "continuation" of the 1989 injury and that there was a material relationship between that injury and claimant's current right shoulder difficulties. (Ex. 50-9). For the first time, instability in claimant's right shoulder was reported. Dr. Baker wrote that the right shoulder condition of which claimant was currently complaining was "essentially the same" condition that claimant demonstrated in the February 1991 examination, which Dr. Baker had observed.

In his deposition, Dr. Baker amplified his opinion. (Ex. 53). Dr. Baker indicated that he disagreed with Dr. Bocian's diagnosis of bursitis and latissimus dorsi strain. Instead, Dr. Baker reiterated his diagnosis of suspected traumatic right shoulder arthritis likely related to the 1989 injury and an unstable right shoulder with recurrent subluxation related to the 1989 injury. Dr. Baker related claimant's condition to the 1989 injury in large part because of claimant's history that, when he injured his right shoulder in 1989, he felt his shoulder slip in and out of joint. According to Dr. Baker, this indicated claimant's compensable injury in 1989 had caused instability in his right shoulder which had persisted with activity since that time. In addition, Dr. Baker noted claimant's history that his right shoulder symptoms had not changed since 1989. (Ex. 53-23).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that Dr. Baker's opinion was the most persuasive concerning the causation issue. Reasoning that Dr. Baker's opinion was based on a complete and accurate history, and was the only opinion to address the significance of claimant's feeling of shoulder dislocation at the time of the 1989 injury, the Referee found that claimant dislocated his shoulder in 1989 and that claimant's current right shoulder condition was the "same condition" as caused by the 1989 injury. The Referee also determined that, to the extent that a claim was made for arthritis, this condition was a compensable consequential condition resulting from the 1989 injury.

Applying ORS 656.308(1), the Referee found that the 1989 injury was the major contributing cause of claimant's current need for medical treatment. See SAIF v. Drews, 388 Or 1 (1993). Thus, the Referee concluded that Liberty remained responsible for claimant's current right shoulder condition.

On review, Liberty contends that the Referee erred in finding Dr. Baker's to be the most persuasive medical opinion. It asserts that claimant's current right shoulder condition is not the "same condition" as resulted from the 1989 injury and that responsibility should be determined under the Last Injurious Exposure Rule (LIER). According to Liberty, when that rule is applied, SAIF should be held responsible for claimant's current right shoulder condition. We agree.

Applicability of ORS 656.308(1)

We consider first whether ORS 656.308(1) applies to this claim. To answer this question we need to determine if claimant's current right shoulder condition for which he seeks compensation involves the "same condition" as the prior accepted claim processed by Liberty. See Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993).

The medical evidence is divided as to whether claimant's current shoulder condition involves the "same condition" as the claim accepted by Liberty. When there is a dispute between medical experts, we give more weight to medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We tend to give greater weight to the conclusions of claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

Unlike the Referee, we find no persuasive reasons to discount the opinion of the attending physician, Dr. Bocian. Although Dr. Bocian initially related claimant's current right shoulder condition to the 1989 injury, upon review of additional medical records, Dr. Bocian concluded that claimant's current right shoulder condition was different from the condition present in 1989. Specifically, Dr. Bocian stated his findings clearly indicated that claimant's current condition was bursitis and latissimus dorsi muscle strain, which were new conditions unrelated to the 1989 injury. Dr. Bocian remarked that prior examinations in 1989 and 1991 documented different findings from those present in August 1992, when he first examined claimant.

We find Dr. Bocian's change of opinion to be reasonable in light of his explanation. See Kelso v. City of Salem, 87 Or App 630, 633 (1987). Therefore, his prior inconsistent opinions do not undermine his current medical opinion.

We note that Dr. Bocian's opinion is supported by those of examining physicians Neufeld and Wilson, who also concluded that claimant's 1989 shoulder strain had resolved and that his current right shoulder condition is not related to the 1989 injury. (Ex. 44-5, 6). In addition, Dr. Carter wrote on November 30, 1992 that his examination in May 1989 did not detect bursitis or a right latissimus dorsi muscle strain. (Ex. 42). From this, we find additional support for Dr. Bocian's conclusion that claimant's current condition is different from what resulted from the 1989 injury. In light of this, we do not find persuasive reasons to discount Dr. Bocian's medical opinion. Instead, we find his medical opinion to be well-reasoned and based on an accurate history. We, therefore, find it to be persuasive. See Somers v. SAIF, supra.

The only contrary opinion is from Drs. Barth and Baker, in particular Dr. Baker, who observed an examination of claimant in February 1991 and authored the June 1993 medical report. The Referee found Dr. Baker's opinion to be the most persuasive. We disagree.

Although he disagreed with Dr. Bocian's diagnosis, Dr. Baker implicitly conceded in his deposition that Dr. Bocian's diagnosis may have been correct because claimant's bursitis and latissimus dorsi muscle strain could have resolved prior to his examination of claimant in June 1993. (Ex. 53-10). Dr. Baker also conceded that Dr. Bocian's findings were characteristic of deltoid bursitis. (Ex. 53-21). Given these concessions by Dr. Baker, we do not find that Dr. Bocian's diagnosis was necessarily incorrect, as SAIF argues.

The key factor in Dr. Baker's opinion is his belief that claimant experienced shoulder instability as a result of the 1989 injury. This was based on claimant's reporting of a "clunk" and of a feeling of instability at the time of the original injury in 1989. According to Dr. Baker, this was consistent with his current finding of right shoulder instability. On this basis, Dr. Baker opined that that the "major contributing cause" of claimant's current condition was instability resulting from the 1989 injury. (Ex. 53-24).

However, right shoulder instability had never been detected prior to Dr. Baker's June 1993 examination. Dr. Baker testified that shoulder instability probably could not have been detected within several days of the 1989 injury because of likely guarding or splinting of claimant's shoulder. (Ex. 53-26). Significantly, however, Dr. Baker testified that instability should be discernible within three or four weeks of the injury. (Ex. 53-26).

In this regard, the most crucial evidence is provided by Dr. Carter's May 11, 1989 examination, nearly three weeks after claimant's injury. Dr. Carter specifically reported no evidence of shoulder instability. (Ex. 5-1). Moreover, Dr. Carter gave no indication in his report that claimant was guarding his right shoulder. Given Dr. Baker's testimony that instability should have been evident within several weeks of the injury, we conclude that Dr. Carter's examination, as well as the lack of any contemporaneous diagnosis of instability, is persuasive evidence that claimant did not sustain shoulder instability as a result of the 1989 injury. Because of this, we conclude that Dr. Baker's opinion that claimant's current condition is related to the 1989 injury is based on an erroneous assumption.

Accordingly, we find that Dr. Baker's opinion is not persuasive. See Loreta King, 46 Van Natta 1270, 1271 (1994). We, therefore, conclude that claimant's current right shoulder condition is not the "same condition" as resulted from the 1989 injury. ORS 656.308(1) is not applicable.

Application of LIER

Having found that ORS 656.308(1) does not apply because claimant's current shoulder condition is not the "same condition" as that which resulted from his original injury in 1989, we agree with Liberty that responsibility should be determined under LIER. This rule governs the initial assignment of responsibility for conditions not previously accepted. See Steven K. Bailey, 45 Van Natta 2114 (1993). The rule may be invoked if the claimant has worked for more than one employer that could have contributed to an occupational disease; it assigns liability for the disease to the potentially causal

employer on the risk at the time of onset of disability. E.g., Bracke v. Baza'r, 293 Or 239, 248 (1982). The claimant need only prove that the disease was caused by employment-related exposure; whether one workplace actually caused the disease is irrelevant. Runft v. SAIF, 303 Or 493, 500 (1987).

Here, there is no dispute that claimant's current right shoulder condition is compensable. Thus, applicability of the last injurious exposure rule is appropriate. See Bracke v. Baza'r, supra; Runft v. SAIF, supra. Inasmuch as claimant became disabled (i.e., first sought medical services for his "new" shoulder condition) while working for SAIF's insured in 1992, SAIF is deemed responsible for the claim. See Timm v. Maley, 125 Or App 396, 401 (1994).

Moreover, SAIF provides no persuasive medical evidence that claimant's 1989 injury was the sole cause of his current right shoulder condition or that it was impossible for work at its insured to have caused the disease. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374 (1984). In this regard, we note that Dr. Bocian stated that claimant's employment for SAIF's insured could have caused claimant's burstis and latissimus dorsi strain. Thus, Dr. Bocian's opinion, which we have already determined to be persuasive, establishes that it was not impossible for claimant's employment at Surco to have caused claimant's right shoulder condition. Inasmuch as Dr. Bocian, as supported by the Neufeld/Wilson panel, has opined that claimant's current shoulder condition is not related to the 1989 injury, it follows that the 1989 injury is not the sole cause of claimant's current condition. Thus, there is no basis for shifting responsibility to Liberty. FMC Corp. v. Liberty Mutual Ins. Co., supra. Accordingly, we conclude that SAIF is responsible for claimant's right shoulder condition.

ORDER

The Referee's order dated January 3, 1994 is reversed. Liberty's denial of responsibility is reinstated and upheld. SAIF's denial of responsibility on behalf of Surco Logging, Inc. is set aside, and the claim is remanded to SAIF for processing according to law. SAIF is responsible for the attorney fee granted by the Referee. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
BARBARA L. WHITING, Claimant
WCB Case No. C4-01575
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, et al., Claimant Attorneys
R. Michael Healey, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On June 23, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

On July 6, 1994, the Board requested an addendum requiring correction of language typically included in a disputed claim settlement. Specifically, the CDA states:

> "IT IS FURTHER STIPULATED AND AGREED that this settlement shall resolve all issues or claims that were raised or could have been raised as of the date of the approval of this settlement." (P. 5, Ln. 12-14). Emphasis supplied).

We have previously disapproved a CDA which contained similar language. Victor F. Lambert, 42 Van Natta 2707 (1990). In Lambert, the proposed agreement stated that the parties agreed that the disposition resolved "all issues currently raised or raisable" concerning "outstanding claims for workers' compensation benefits, whether filed or not." (Emphasis supplied). Furthermore, the Board has disapproved CDA's involving or referring to denied claims. See Donald Rhuman, 45 Van Natta 1493 (1993); Frederick M. Peterson, 43 Van Natta 1067 (1991).

On July 18, 1994, the Board received the self-insured employer's response to our request to correct the abovestated language. The employer attempts to distinguish the language in Lambert and the current CDA, stating that Lambert releases rights and obligations not only under claimant's accepted claim, but also "under any other outstanding claims * * *, whether filed or not," whereas the language in the instant CDA releases rights and obligations only under the accepted claim.

Notwithstanding the employer's argument, we continue to conclude that the language in the current CDA is language typically found in a Disputed Claim Settlement, and may be construed to refer to claims other than the accepted claim. Although the employer argues that its language pertains to only the accepted claim, the broad language provided in the CDA does not contain any such limitations. Furthermore, the employer has declined to amend the CDA or to correct the language to clearly provide for such a limitation. Additionally, it is claimant's position that the "raised and raisable" language be stricken from the CDA.

Accordingly, under the circumstances described herein, because the parties have not submitted an addendum eliminating the specified "raised or raisable" language, we find that the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2)(b); Victor F. Lambert, supra. We therefore decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed dispositions. See OAR 436-60-150(4)(i) and (6)(e).

The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
JOYCE M. RUSSELL, Claimant
WCB Case No. 93-10627
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
H. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Podnar's order that upheld the SAIF Corporation's denial of her cervical, thoracic, and lumbar spine myofascial pain syndrome/somatoform pain syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except we replace the third sentence in the third full paragraph on page 2 with:

On April 2, 1992, Dr. Naito noted that claimant's low back range of motion is "still limited." This is the first mention of a low back problem in the record.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the Referee's opinion that claimant's myofascial pain syndrome/somatoform pain syndrome is not compensable, with the following comments.

On review, claimant argues that SAIF conceded at hearing that her neck, shoulder, upper back, and low back symptom complex is compensable. We disagree.

Claimant fell on her right side in November 1991. Claimant's physicians variously diagnosed her condition as thoracic strain, right trapezius strain, cervical strain, and myofascial pain syndrome/somatoform pain syndrome. SAIF accepted claimant's thoracic strain and right trapezius strain. SAIF neither accepted nor denied claimant's cervical or low back conditions.

At hearing, claimant argued that SAIF had de facto denied her cervical, thoracic, and lumbar spine myofascial pain syndrome. SAIF acknowledged that it had "not denied anything in this case." Tr. 10. We do not find that SAIF's admission that it had de facto denied the contested conditions constitutes a "concession" that those conditions are compensable, especially in light of SAIF's subsequent argument that there is no evidence that claimant's complaints, including her myofascial pain syndrome, "are causally related to her fall." Tr. 15.

Moreover, we agree with the Referee that the record does not support claimant's contention that her myofascial pain syndrome/somatoform pain syndrome is related to the compensable injury. Dr. Naito first treated claimant on February 12, 1992 for her November 1991 injury. By March 16, 1992, claimant was improving with prescribed physical therapy. However, when claimant returned for a follow-up visit on April 2, 1992, she complained of increased discomfort. Dr. Naito noted that although claimant denied the role of grief in her pain complaints, she was upset by the recent murder of her father.

By April 14, 1992, claimant's musculoskeletal pain symptoms had worsened further. Dr. Naito recommended that claimant see a psychologist; claimant declined. Dr. Naito opined that claimant:

> "still maintains that her father's recent murder has had very little, if any impact on her and certainly is not increasing her pain. She now believes that her pain has always been this bad. . . . This injury is now approximately four months old and, with her worsening symptoms or complaints, I believe that there must be another issue going on here. If it is not depression and grief reaction, then there must be something else causing her to miss work entirely."

SAIF referred claimant for examination on September 16, 1992. Psychologists Kolbell and Gostnell diagnosed "somatoform pain disorder, related to injury," and "operantly maintained pain behaviors." Notwithstanding the phrase "related to injury," we find that the substance of their report does not relate claimant's somatoform pain disorder to the compensable injury, but rather to claimant's psychological makeup.

Drs. Kolbell and Gostnell found that claimant has a strong need for attention and affection, is unable to express her negative emotions, and lacks insight into the relationship between her psychological functioning and physical functioning. They opined that because claimant is unable to express her negative emotions, she converts her psychological conflict into somatic pain behaviors which are more socially acceptable. As we read Dr. Kolbell and Gostnell's report, they relate claimant's somatoform pain disorder to claimant's inherent psychological constitution, not to her compensable injury.

For these reasons, as well as those expressed by the Referee, we find that claimant's cervical, thoracic, and lumbar spine myofascial pain syndrome/somatoform pain syndrome is not related to the compensable 1991 injury.

ORDER

The Referee's order dated December 22, 1993 is affirmed.

August 30, 1994 Cite as 46 Van Natta 1717 (1994)

In the Matter of the Compensation of
SUSAN K. CLIFT, Claimant
WCB Case No. 92-13250
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband, and Neidig.

The insurer requests review of that portion of Referee Baker's order which set aside its denial of claimant's occupational disease claim for a myofascial pain condition of both arms. Claimant cross-requests review of that portion of the Referee's order which upheld the insurer's denial of a mental disorder claim for a temporary adjustment disorder. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Bilateral Arm Condition

Relying on the opinion of Dr. Long, claimant's treating physician, the Referee concluded that claimant's bilateral arm condition, which Dr. Long diagnosed as a myofascial pain disorder, was caused in major part by her work activities. After our review of the record, we agree with the Referee's reasoning. We find Dr. Long's opinion particularly persuasive because only his diagnosis and treatment actually cured claimant. In addition, we find his opinion to be well-reasoned and based on complete information. (See Exs. 89b, 89d, 91, 94a-2, 96, and 103 at 10-11, 13-15). Accordingly, we too conclude that claimant has established, by a preponderance of the evidence, that her bilateral arm condition is compensable as an occupational disease. ORS 656.802.

Psychological Condition

The Referee upheld the insurer's denial of a claim for temporary anxiety adjustment disorder, on the ground that claimant failed to establish the claim by clear and convincing evidence. In so holding,

the Referee apparently applied ORS 656.802, requiring claimant to prove the compensability of her mental disorder as an occupational disease. Because we believe the parties litigated the mental disorder claim on another theory, at least in the alternative, we disagree with the Referee's analysis and conclusion.

At hearing, the parties agreed that the mental disorder claim is based on the theory that claimant's psychological condition is a secondary consequence of a compensable physical condition. (Tr. at 23-26). Under that theory, in order to establish compensability of her mental disorder, claimant must prove that her compensable physical condition is the major contributing cause of her psychological condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Boeing Co. v. Viltrakis, 112 Or App 396 (1992). Claimant need not prove her claim by clear and convincing evidence. Compare ORS 656.802(3).

Here, Dr. Deale, claimant's treating psychiatrist, opined that claimant's arm pain was the major contributing cause of her psychological condition and need for treatment. (See Ex. 94 at 6, 12-13, 41-42). We have affirmed the Referee's order finding that claimant's arm pain is a compensable myofascial pain condition. Therefore, unless we find it unpersuasive for some reason, Dr. Deale's opinion establishes that claimant's compensable arm pain condition is the major contributing cause of her mental disorder.

Dr. Turco, a psychiatrist who examined claimant at the insurer's request, opined that claimant's psychological condition is unrelated to her compensable work injury. (See Exs. 85-8, 104 at 42-43). However, his opinion is based on the premise that there is no physical basis for claimant's arm pain. (Exs. 85 at 6-7, 104-19). That premise is inconsistent with our finding that claimant's arm pain is a compensable physical condition; i.e., a myofascial pain disorder. Therefore, we find Dr. Turco's opinion to be less persuasive.

When medical evidence is divided, we generally give greater weight to the treating doctor's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no reason not to defer to the treating psychiatrist's opinion in this case.

We find that Dr. Deale's opinion is sufficiently explained, well-reasoned and based on an accurate history. Given our conclusion that claimant's arm pain is compensable, Dr. Deale's opinion establishes that claimant's psychological condition is compensable as a secondary consequence of her compensable arm condition. As noted above, we find Dr. Turco's opinion less persuasive. Accordingly, we set aside the insurer's denial with respect to both a psychological condition and bilateral arm pain.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of her psychological condition. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the psychological condition is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate brief and the hearing record), the complexity of the issue, and the value of the interest involved.

In addition, claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the myofascial pain condition is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 27, 1993 is affirmed in part and reversed in part. That portion of the order which upheld the insurer's denial of temporary anxiety adjustment disorder is reversed. The insurer's denial of claimant's current psychological condition is set aside, and the claim is remanded to the insurer for processing in accordance with law. The remainder of the order is affirmed. In addition to the Referee's attorney fee award, claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the insurer.

Board Chair Neidig dissenting in part.

I disagree with that portion of the majority's decision which finds claimant's adjustment disorder compensable as a "consequential condition." Therefore, I offer this dissenting opinion.

In denying claimant's "psychological condition," the insurer asserted that the condition was unrelated to claimant's "job-related injury to your wrists." (Ex. 86). Thus, in issuing its so-called "Partial Denial," the insurer interpreted claimant's "psychological" claim to be based on a theory that the condition was causally related to her compensable injury. In other words, the claim was initially premised on a "consequential condition" theory under ORS 656.005(7)(a)(A).

Claimant also advanced this "consequential condition" theory at the hearing. However, she further asserted that her psychological condition was related to her work activities. (Tr. 23). Despite this assertion, claimant's counsel subsequently agreed with the Referee's and the insurer's counsel's representations that the claim was not for "mental stress" but was a "physical/mental claim." (Tr. 24).

Following the hearing, claimant's counsel clarified claimant's compensability theories by means of written closing arguments. Claimant's counsel explained that there were two separate conditions in dispute: (1) a temporary adjustment disorder; and (2) a myofascial pain syndrome. It was claimant's position that the myofascial pain syndrome was a compensable occupational disease and that the adjustment disorder was a compensable mental disorder. Although claimant's counsel's closing arguments listed ORS 656.005(7)(a)(A) under a section of the closing argument entitled "Applicable Law," claimant did not present an argument asserting that the adjustment disorder was causally related to her compensable wrist injury. Instead, she expressly asserted that she had "met all of the elements of proving a mental disorder under ORS 656.802(3)."

Based on claimant's "mental disorder" theory for her adjustment disorder condition, the Referee concluded that claimant had not satisfied the statutory prerequisites of ORS 656.802(3). Consequently, the Referee properly upheld the insurer's denial insofar as it pertained to claimant's adjustment disorder.

On review, claimant did not alter her theory for the compensability of her adjustment disorder condition. Moreover, she did not contend that the Referee erred in analyzing her adjustment disorder as a mental disorder claim rather than as a "consequential condition." In fact, her respondent/cross-appellant's brief is essentially identical to her prior written closing arguments. In other words, notwithstanding a passing reference to ORS 656.005(7)(a)(A), claimant expressly contends that she "has met all of the elements of proving a mental disorder claim under ORS 656.802(3)."

In light of claimant's clear and unambiguous argument, I submit that the Board should confine itself to the specific question presented. As did the Referee, the Board should solely address the issue which claimant has explicitly framed on two separate occasions; i.e., does claimant's adjustment disorder constitute a compensable mental disorder claim under ORS 656.802(3).

For the reasons expressed by the Referee, I believe that the answer to the question posed in claimant's written closing argument and repeated in her cross-appellant's brief is unequivocally "no." Because the majority strays from claimant's theory of compensability and answers a question that claimant has not asked, I submit that they commit error.

In the Matter of the Compensation of
LINDA D. MERRITT, Claimant
WCB Case No. 93-09402
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee T. Lavere Johnson's order that: (1) affirmed an Order on Reconsideration that awarded claimant 28 percent (53.76 degrees) scheduled permanent disability for loss of use or function of the right arm and 63 percent (120.96 degrees) scheduled permanent disability for loss of use or function of the left arm; and (2) assessed a penalty pursuant to ORS 656.268(4)(g). On review, the issues are evidence, extent of scheduled permanent disability and penalties. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Exhibit 16

The attending physician, Dr. Mandiberg, did not initially make his own impairment findings. Rather, impairment findings were made by the insurer's examiners, Drs. Snodgrass and Arbeene, on December 11, 1992. They reported, in part:

> "For purposes of rating impairment, we believe that it would be reasonable to consider the peripheral nerves involved in producing [claimant's] weakness to be the musculocutaneous nerve for biceps and elbow flexion, the radial nerve for triceps and wrist extension, and the median nerve for gripping." (Ex. 9).

Dr. Mandiberg concurred with Drs. Snodgrass and Arbeene in a "check-the-box" letter. (Ex. 11).

Exhibit 16 is a "check-the-box" report signed by Dr. Snodgrass on July 30, 1993, that clarifies the December 11, 1992 independent medical examination (IME) report. Relying on Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994), the Referee declined to consider Exhibit 16 because Dr. Mandiberg did not concur in Dr. Snodgrass' report and, in fact, issued a subsequent opinion contrary to Dr. Snodgrass.

The insurer contends that Dr. Snodgrass' July 30, 1993 opinion is not a separate IME opinion which is barred by Koitzsch v. Liberty Northwest Ins. Corp., supra. According to the insurer, Dr. Snodgrass' July 30, 1993 opinion merely clarifies the December 11, 1992 report.

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure can make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., supra (Board violated ORS 656.245(3)(b)(B) by receiving and considering impairment findings of an independent medical examiner). Here, no medical arbiter was appointed. Impairment findings from a physician, other than the attending physician, may be used, however, if those findings are ratified by the attending physician. See Roseburg Forest Products v. Owen, 129 Or App 442 (August 10, 1994). Because Dr. Mandiberg did not ratify Dr. Snodgrass' July 30, 1993 "clarification," the Referee did not err by not considering that report.

Exhibit 17

On August 2, 1993, after the Order on Reconsideration was issued, Dr. Mandiberg agreed with the following letter from the insurer:

> "This is to confirm our conversation of today and to serve as clarification of the closing examination report of 12/11/92 in the above-referenced claim.
>
> "It was your opinion that, in light of [claimant's] on-going pain complaints and inhibition at performing grip strength testing, there was some muscle separation [from the bone] at the lateral epicondyles. This would be innervated by the Radial nerve only. It was your estimate that the residual function could be rated at 4/5 bilaterally." (Ex. 17).

The insurer asserts that Dr. Mandiberg's August 2, 1993 opinion should be considered even though it was issued after the Order on Reconsideration because his remarks were addressed to claimant's condition as of December 11, 1992 and is a clarification of that report. Claimant agrees that Dr. Mandiberg's August 2, 1993 opinion is admissible, but she contends that his rating of her muscle strength as 4/5 cannot be considered because that rating was after the Order on Reconsideration issued.

ORS 656.283(7) directs referees to evaluate a worker's permanent disability as of the time of the reconsideration order. We have interpreted this provision as designating a point in time at which a worker's permanent disability is evaluated. Gary C. Fischer, 46 Van Natta 60 (1994). Medical evidence that is generated after the date of the reconsideration order, but which addresses a worker's permanent impairment as of the date of the reconsideration order is also relevant and material evidence under ORS 656.283(7). Scheller v. Holly House, 125 Or App 454 (1993) (post-reconsideration order medical evidence admissible under ORS 656.283(7) where no medical arbiter was appointed pursuant to ORS 656.268(7)).

There is no evidence that claimant was seen by Dr. Mandiberg subsequent to the Order on Reconsideration. Moreover, Dr. Mandiberg's August 2, 1993 letter indicates that he was addressing claimant's condition as of the December 11, 1992 examination. The letter states that it serves "as clarification of the closing examination report of 12/11/92." Therefore, we conclude that Exhibit 17 is relevant and should be considered in its entirety.

Extent of Scheduled Permanent Disability

The insurer argues that claimant is not entitled to an award for loss of strength because the December 11, 1992 report stated that "In all instances, her weakness appears to be secondary to pain." (Ex. 9). We disagree. The December 11, 1992 report also stated that "For purposes of rating impairment, we believe that it would be reasonable to consider the peripheral nerves involved in producing her weakness * * *." (Id.) Furthermore, the worksheet attached to the Order on Reconsideration stated that "Strength loss is an objective finding even though caused by pain. There is no evidence that would discredit the strength loss described." (Ex. 15).

The Referee reviewed Dr. Mandiberg's August 2, 1993 report and reasoned that it supported the disability awards made in the Order on Reconsideration. In contrast, we find that the report supports only a portion of the disability awards made by the Appellate Review Unit.

When read as a whole, we interpret Dr. Mandiberg's concurrence with the December 11, 1992 report and his August 2, 1993 "clarification" to be that claimant is entitled to an award of loss of strength due to a peripheral nerve injury. OAR 436-35-110(8). The December 11, 1992 report said: "For purposes of rating impairment, we believe that it would be reasonable to consider the peripheral nerves involved in producing her weakness to be * * * the radial nerve for triceps and wrist extension * * *." (Ex. 9). Dr. Mandiberg's August 2, 1993 opinion stated that "there was some muscle separation [from the bone] at the lateral epicondyles. This would be innervated by the Radial nerve only. * * * [T]he residual function could be rated at 4/5 bilaterally." (Ex. 17). We find that claimant's radial nerve (upper arm with loss of triceps) has an impairment value of 55 percent. OAR 436-35-110(8). Applying OAR 436-35-007(14) gives claimant 11 percent of each arm for loss of grip strength (20 percent of 55 percent).

The insurer does not dispute that claimant is entitled to the following: 5 percent for chronic condition impairment of her left arm; 6 percent for loss of range of motion for her left arm and 1 percent for loss of range of motion for her right arm. Thus, claimant's award for the right arm is reduced to 11 percent for loss of grip strength and 1 percent for loss of range of motion, for a total of 12 percent. Claimant's award for the left arm is reduced to 11 percent for loss of grip strength, 6 percent for loss of range of motion and 5 percent for chronic condition impairment, for a total of 22 percent.

Penalty Under ORS 656.268(4)(g)

The Notice of Closure awarded claimant scheduled permanent disability of 11.52 degrees for 6 percent for loss of her right arm and scheduled permanent disability of 21.12 degrees for 11 percent for loss of her left arm. (Ex. 13). On reconsideration, the Department increased the total scheduled award to 28 percent on the right arm and 63 percent on the left arm and ordered the insurer to pay a penalty pursuant to ORS 656.268(4)(g). (Ex. 15).

ORS 656.268(4)(g) authorizes assessment of a penalty against an insurer or self-insured employer if, upon reconsideration of a notice of closure, the following two conditions are met: (1) the claimant is found to be at least 20 percent permanently disabled; and (2) the Department orders an increase by 25 percent or more of the amount of compensation to be paid to the claimant for permanent disability. Here, on reconsideration, both of these requirements were met. If the Board reduces the permanent disability award, but the award still qualifies for a penalty under ORS 656.268(4)(g), then the amount of the penalty shall be reduced proportionately to the award reduction, i.e., 25 percent of the reduced permanent disability award which is "then due." Vena K. Mast, 46 Van Natta 34 (1994).

Although we have reduced claimant's permanent disability award, it still qualifies for a penalty pursuant to ORS 656.268(4)(g). The Notice of Closure awarded claimant a total of 17 percent. (Ex. 13). We have increased that award to a total of 34 percent (12 percent plus 22 percent), which is an increase of 25 percent or more. See Nero v. City of Tualatin, 127 Or App 458 (1994). Therefore, claimant is awarded a penalty equal to 25 percent of the amount due by virtue of our order. The Referee's award of a penalty is modified accordingly.

ORDER

The Referee's order dated January 12, 1994 is modified. The scheduled permanent disability awards for claimant's right and left arms, as granted by the Referee's order and the Order on Reconsideration, are reduced to 12 percent (23.04 degrees) scheduled permanent disability for her right arm and 22 percent (42.24 degrees) scheduled permanent disability for her left arm. In lieu of the Referee's penalty assessment, claimant is awarded a penalty pursuant to ORS 656.268(4)(g) equal to 25 percent of the amounts of permanent disability due by virtue of this order.

In the Matter of the Compensation of
ROBERTO RODRIGUEZ, Claimant
WCB Case No. 93-06124
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes, Hall, and Westerband.

The SAIF Corporation requests review of that portion of Referee Emerson's order that affirmed the Order on Reconsideration award of 31 percent (99.2 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of his finding that claimant has objective impairment of the lumbar spine due to loss of range of motion. We find, instead, that claimant has no permanent losses of range of motion in the lumbar spine.

CONCLUSIONS OF LAW AND OPINION

The sole issue is whether claimant has permanent impairment as a result of the compensable low back strain which occurred on December 7, 1990. The Referee found permanent impairment due to losses of range of motion in extension and left and right lateral flexion. On review, SAIF contends that the range of motion findings are not reliable and should not be the basis for any permanent disability award. We agree.

Burden of Proof

As a preliminary matter, SAIF contests the Referee's conclusion that it has the burden of proof in this matter. The Referee relied on ORS 656.283(7) to place the burden of proof on SAIF. SAIF acknowledges that, pursuant to ORS 656.283(7), it would have the burden to prove that the standards for rating disability were incorrectly applied by the Department. However, SAIF contends that it is not arguing that the standards were incorrectly applied. Instead, SAIF's argument is that there are no valid impairment findings in the Order on Reconsideration. Citing ORS 656.266, SAIF argues that claimant has the burden of proving impairment and disability.

ORS 656.283(7) provides, in part:

> "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

We find that SAIF's distinction between whether the standards were incorrectly applied and whether the impairment findings were valid is a distinction without a difference. If there are no valid impairment findings, it necessarily follows that the standards were incorrectly applied. SAIF's argument construes ORS 656.283(7) too narrowly. The Referee properly relied on ORS 656.283(7) to place the burden of proof on SAIF.

This conclusion does not conflict with ORS 656.266. Rather, our analysis is entirely consistent with the statutory scheme as set forth in ORS 656.266, 656.268 and 656.283(7). We base this conclusion on the following reasoning.

A September 25, 1992 Determination Order awarded claimant no permanent disability. (Ex. 23). After claimant requested reconsideration and was examined by medical arbiters, a May 26, 1993 Order on Reconsideration awarded 31 percent (99.20 degrees) unscheduled permanent disability. (Ex. 29). Thereafter, prior to the expiration of the 180 day appeal period of ORS 656.268(6)(b), both claimant and SAIF filed a request for hearing to challenge the Order on Reconsideration. However, claimant subsequently withdrew his request for hearing. Thus, at hearing, SAIF was the only party registering dissatisfaction with the reconsideration order. Since SAIF was the dissatisfied party, SAIF had the burden of establishing that the standards had been incorrectly applied. See ORS 656.283(7).

This conclusion not only comports with the statutory scheme, but it is consistent with prior case precedent. In Harris v. SAIF, 292 Or 683, 690 (1982), the Supreme Court explained the general rule regarding the allocation of the burden of proof:

> "The general rule is that the burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side."

In Harris v. SAIF, supra, the claimant had been awarded permanent total disability several years earlier and SAIF sought a reduction in the award, claiming a change of circumstances. The threshold issue was which party had the burden of proof. The Court distinguished between adjudication of the initial claim for permanent disability and a subsequent proceeding under ORS 656.206 in which the insurer seeks a reduction in a prior final award based on a change in circumstances. The Court said:

> "It is quite clear that a disability claimant seeking, in the first instance, permanent total disability status has the burden of proving that he is so disabled * * *. As the Bentley [v. SAIF, 38 Or App 473 (1979)] quote above notes, however, there is no express statutory provision dealing with burden of proof in award adjustment proceedings." 292 Or at 689 (emphasis added).

Here, SAIF's position, as the party challenging claimant's entitlement to permanent partial disability, is akin to the insurer's position in Harris v. SAIF, supra, in the award adjustment proceeding. Although, under ORS 656.266, the claimant clearly has the burden of proof in the first instance, the party who appeals the prior preceding award has the burden of proof in a subsequent proceeding. See Harris v. SAIF, supra; see also Earl D. Lesperance, 45 Van Natta 2133 (1993) (carrier contesting reconsideration order award of permanent total disability had burden to prove that the claimant was not permanently and totally disabled).

Here, had SAIF not timely requested a hearing to challenge the Order on Reconsideration, the order would have become final. See ORS 656.268(6)(b). Thus, because SAIF was the "dissatisfied party" (the proponent for changing the status quo), it had the burden not only to request a hearing, but to present evidence and arguments in support of its position. This reasoning is consistent with ORS 656.283(7), which provides that a party (the worker, the insurer or the self-insured employer) may present evidence at hearing to establish by a preponderance that the standards for evaluation of the worker's permanent disability were incorrectly applied. That statute does not conflict with ORS 656.266.

Under ORS 656.266, claimant has the obligation to prove the nature and extent of any disability. In the present case, when requesting reconsideration of the Determination Order, claimant was obligated to prove the nature and extent of his permanent disability in accordance with ORS 656.266. He successfully satisfied that statutory prerequisite when the Order on Reconsideration awarded 31 percent unscheduled permanent disability. Claimant no longer challenges that order. Instead, SAIF, the dissatisfied party under ORS 656.268(6)(b), requested a hearing objecting to claimant's reconsideration order award. As the dissatisfied party, it is incumbent on SAIF ("the insurer") to establish that the standards were incorrectly applied. ORS 656.283(7). The Referee did not err in assigning the burden of proof to SAIF.

Merits

The Department's Appellate Review Unit assigned an impairment value of 7, based on the range of motion findings in the April 27, 1993 examination report by medical arbiters, Drs. Bald and Lyon. In that report, Drs. Bald and Lyon wrote:

> "Measurement of lumbar range of motion using the double inclinometer method is as follows: Maximum lumbar flexion 40 degrees, maximum lumbar extension 12 degrees, maximum right lateral bending 16 degrees, and maximum left lateral bending 18 degrees. Maximum straight leg raising on the right is 28 degrees and maximum straight leg raising on the left is 24 degrees. Total sacral (hip) motion is 10 degrees. This does not satisfy the reproducibility-reliability criteria as defined by the 3rd Edition AMA."[1] (Ex. 28-3, emphasis supplied).

The Appellate Unit rejected the lumbar flexion measurement as invalid, but accepted the arbiters' remaining range of motion measurements without addressing their validity. (See Ex. 29-4). Based on the comment emphasized above, however, we find that the arbiters were doubtful of the reliability of all of their range of motion measurements, not just for lumbar flexion. Indeed, the arbiters specifically noted "significant histrionic-type pain behavior during the course of the examination." (Ex. 28-3). Accordingly, we do not rely on the arbiters' range of motion measurements in making our impairment findings.

Furthermore, we find overwhelming evidence in the record of non-organic pain behavior by claimant. Each of these "non-attending physician" observations received a concurrence from Dr. Danner, claimant's attending physician. Under such circumstances, these impairment findings may be considered. See OAR 436-10-080(5); Alex J. Como, 44 Van Natta 221 (1992). The aforementioned observations are as follows.

Prior to becoming medically stationary, on February 4, 1992, claimant was examined by Drs. Watson and McKillop at SAIF's request. They measured losses of lumbar range of motion but concluded those losses were invalid. They noted that examination findings were somewhat contradictory and associated with "pain behavior." They could not identify any legitimate orthopedic or neurological impairment. (Ex. 11-4). Claimant's attending physician, Dr. Danner, concurred with those findings. (Ex. 12).

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[1] The "3rd Edition AMA" apparently refers to the American Medical Association's Guides to the Evaluation of Permanent Impairment, 3rd Edition. The Director's rules provide that only the methods described in the AMA Guides and methods the Director prescribes by bulletin shall be used to measure impairment. OAR 436-35-007(4).

On June 1, 1992, claimant's medically stationary date, he was examined by Dr. Ayers at SAIF's request. Dr. Ayers measured losses of range of motion but concluded that "spinal ranges of motion should not be used as a basis for rating impairment, since he has significant evidence of non-physiologic pain behavior, which would preclude using his measurements in an objective manner to determine disability, and also the fact that things do not match, or are inconsistent..." (Ex. 16-5). Dr. Ayers concluded that claimant had no impairment findings and could perform regular work, including heavy lifting. (Id.) Dr. Danner concurred with Dr. Ayers' report, except that he felt that claimant's lifting should be limited to the medium range. (Ex. 17).

On September 14, 1992, claimant underwent a physical capacity evaluation. Although losses of range of motion were measured, the evaluator commented that the measurements "do not necessarily reflect actual range of motion." The evaluator observed "significant pain behavior associated with these measurements." The evaluator added: "Residual capacity is not determined due to lack of cooperation and apparent symptom magnification syndrome with the apparent purpose of the evaluation, on the client's part, to demonstrate disability as opposed to ability." (Ex. 20-2). Dr. Danner also concurred with the evaluation findings. (Ex. 22).

Based on the aforementioned evidence of non-organic pain behavior (much of which was concurred in by claimant's attending physician), we conclude that the measurements of claimant's lumbar ranges of motion are not reliable. Accordingly, we conclude that the Appellate Unit erred in awarding claimant permanent disability based on range of motion measurements. Inasmuch as the range of motion measurements were the sole impairment finding made by the Appellate Unit, we reverse the Order on Reconsideration's permanent disability award.[2]

ORDER

The Referee's order dated August 20, 1993 is reversed in part and affirmed in part. That portion of the order that affirmed the Order on Reconsideration is reversed. The Order on Reconsideration is modified to award no permanent disability benefits. The Referee's assessed attorney fee award is also reversed. The remainder of the order is affirmed.

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[2] We would reach the same conclusion even if claimant had the burden of proof in this matter.

Board Member Westerband specially concurring.

I agree that the Appellate Unit erred in awarding claimant permanent disability based on range of motion measurements. I write separately, however, because I take exception to the lead opinion's declaration that SAIF has the "burden of proof."

The lead opinion concludes that the Referee properly relied on ORS 656.283(7) to place the "burden of proof" on SAIF. I believe that ORS 656.283(7) does not require the party objecting to the impairment findings in the Order on Reconsideration to produce additional evidence. If it appears at hearing that the record previously made fails to establish that claimant has suffered permanent impairment, claimant will lose without the employer or insurer offering any additional evidence, because, under ORS 656.266, the claimant has the burden of proof.

ORS 656.283(7) does not provide otherwise. Indeed, it says nothing more than that, although the "standards" adopted by the Director must be applied, nothing prohibits either party from showing that the standards were inappropriately applied; and the applicable test is, of course, preponderance of the evidence. ORS 656.283(7) says nothing about which party bears the burden of proof to establish the nature and extent of the claimant's permanent disability.

Furthermore, I disagree with the lead opinion's interpretation of Harris v. SAIF, 292 Or 683, 690 (1982). The Harris court distinguished between adjudication of the initial claim for permanent disability and a subsequent proceeding under ORS 656.206 in which the insurer seeks a reduction in a prior award based on a change in circumstances. I do not agree, however, that SAIF's position here is akin to the insurer's position in Harris v. SAIF, supra, in the award adjustment proceeding.

The present case involves an initial claim for disability, rather than a proceeding subsequent thereto that is similar to the award adjustment proceeding in Harris. Until a final judgment is entered, the parties are still proceeding on the initial claim, no matter what step they are presently at in the proceedings. Under ORS 656.266, the worker has the burden of proving the nature and extent of any disability throughout the proceedings on the initial claim. Therefore, claimant has the burden of proving that he is entitled to an unscheduled permanent disability award.

In most appeals of a reconsideration order, including the instant case, we are asked to review the same evidence that was considered by the Department. To prevail, the insurer is not required to offer new evidence showing a "change in circumstances," and the insurer is not the "party who would be unsuccessful if no evidence were introduced on either side." Harris v. SAIF, supra, 292 Or at 690. Here, SAIF prevailed because claimant failed to carry his burden of proving the nature and extent of any disability resulting from the compensable injury, as ORS 656.266 required.

In the Matter of the Compensation of
RICHARD L. SAUNDERS, Claimant
WCB Case No. 93-14602
ORDER ON REVIEW (REMANDING)
Bischoff & Strooband, Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Schultz's order that dismissed, without a hearing, his request for hearing from the self-insured employer's denial of claimant's injury claim. On review, claimant seeks reversal of the Referee's order and asks that the matter be remanded for a hearing on the merits of his claim. We reinstate claimant's hearing request and remand.

FINDINGS OF FACT

On December 13, 1993, claimant filed a hearing request. The issues raised by the request were the employer's "compensability" denial of December 3, 1993, penalties and attorney fees. The employer moved to dismiss the request for hearing. Submitting supporting affidavit and exhibits, the employer contended that, inasmuch as claimant was not a subject worker, the Hearings Division lacked jurisdiction over the dispute. Contending that claimant was an Oregon subject worker for an Oregon subject employer, claimant argued that the motion for dismissal should be denied. Noting that claimant did not dispute the facts recited in its motion, the employer replied that the dispute could be resolved without a hearing.

Prior to the scheduled hearing, the Referee dismissed claimant's hearing request for lack of jurisdiction. The Referee adopted the argument in the employer's motion that claimant was not a subject worker.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

At the outset, we note that claimant has moved to strike the employer's respondent's brief because he was not provided with exhibits cited in the employer's brief. We deny claimant's motion because the references in the employer's brief to exhibits were made in error. There are no exhibits attached to the employer's brief.

Dismissal of Hearing Request

We now proceed to determine whether the Referee correctly dismissed claimant's request for hearing for lack of jurisdiction. For the following reasons, we conclude that the Referee erred.

The Hearings Division has jurisdiction over all matters concerning a claim. ORS 656.283(1). Here, the employer issued a denial on the grounds that claimant was not a subject worker. Claimant requested a hearing on that denial, which is a "matter concerning a claim." Accordingly, the Referee had jurisdiction over claimant's hearing request. See Ana R. Sanchez, 45 Van Natta 753 (1993) ("Back-up" denial on the basis that claimant was not a subject worker was a "matter concerning a claim"; referee had jurisdiction over hearing request).

Like the referee in Sanchez, the Referee in this case could have upheld or set aside the employer's denial. However, it was not appropriate to reach the merits of the denial and dismiss the hearing request for lack of jurisdiction, without taking any evidence. Ana R. Sanchez, supra. Thus, we reinstate claimant's hearing request.

We are mindful that neither claimant nor the employer apparently disputed the material facts surrounding the subjectivity issue. Moreover, we note that the employer asserted that, since claimant did not dispute the employer's recited facts, an evidentiary hearing was not necessary. Nevertheless, there was no express stipulation by the parties as to the relevant facts. Had there been such a stipulation, it would have been appropriate for the Referee and this forum to perform our review function based on those stipulated and undisputed facts. However, we are unable to conclude that parties mutually agreed to present this dispute for resolution based on stipulated facts. In fact, if any conclusion can be made, based on claimant's opposition to the employer's motion to dismiss the hearing request, it is that claimant desired that the matter proceed to hearing.

In conclusion, without stipulated facts, we hold that the Referee's dismissal of claimant's hearing request without first conducting a hearing was inappropriate. As exemplified by Sanchez, disputes involving "matters concerning a claim" must be decided on the basis of a sufficiently developed hearing record. See also Nancy L. Cook, 45 Van Natta 977 (1993) (The Referee's role is to evaluate the entire record and produce an order containing an organized set of facts and conclusions of law with an explanation why the facts supported by the evidence lead to a conclusion). In light of the Sanchez and Cook rationale, the Referee erred in deciding the subjectivity issue without admitting evidence at a hearing.

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. See ORS 656.295(5). Because the Referee improperly dismissed claimant's request for hearing, and because he did not admit any documentary evidence or take any testimony, we conclude that the record has been incompletely developed. Accordingly, we remand to Referee Schultz for further proceedings consistent with this order to be conducted in any manner that the Referee determines will achieve substantial justice to all the parties.

ORDER

The Referee's order dated April 28, 1994 is vacated. The matter is remanded to Referee Schultz for further proceedings consistent with this order.

In the Matter of the Compensation of
SHARMAN R. CROWELL, Claimant
WCB Case No. 93-13236
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Menashe's order which set aside a Determination Order's classification of claimant's injury claim as nondisabling. On review, the sole issue is claim classification.

We adopt and affirm the Referee's order with the following supplementation.

Claimant, a vinyl frame welder, suffered a compensable left shoulder and right elbow injury on October 21, 1992. Dr. Barnhouse, her attending physician, released claimant for modified work that involved minimal repetitive bending of the right elbow and minimal work at or above the left shoulder level. Claimant later was restricted by another physician to lifting no more than 20 pounds.

Since claimant was not able to perform her regular work with the above restrictions, the employer assigned claimant to a light-duty job putting scotch tape on parts. Claimant was paid her regular wage for the light duty work. Claimant incurred no time loss because of the compensable injury. The employer customarily assigned workers on light duty to do claimant's modified work, but regular workers would do the job if no workers on light duty were available.

On April 14, 1993, the insurer accepted the claim as "nondisabling." Dr. Barnhouse subsequently released claimant for regular work and stated that she would have no permanent impairment. (Exs. 9, 15). On November 3, 1993, a Determination Order ordered that the claim remain classified as nondisabling after claimant requested reclassification of her claim to disabling.

The Referee determined that the claim should be reclassified to "disabling." The Referee reasoned that claimant's injury claim was not about entitlement to temporary disability, but rather about claim classification. Consequently, the Referee concluded that the claim was properly classified as disabling because the injury entitled claimant to temporary disability, but for the employer's ability to accommodate her disability. The Referee cited the court's decision in Stone v. Whittier Wood Products, 124 Or App 117 (1993), as support for his conclusion.

OAR 436-30-045(5)(a) and (d) provide that a claim is "disabling" if temporary disability is "due and payable" or if the worker is released to and doing a modified job at reduced wages from the job at injury. The employer argues that under the above administrative rule claimant is not entitled to reclassification of her claim to disabling because claimant returned to modified work at her regular wages and claimant failed to prove that temporary disability is due and payable. We disagree.

In Stone, supra, the court concluded that temporary partial disability (TPD) must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. In doing so, the court determined that former OAR 436-60-030(2) was inconsistent with ORS 656.212, in that the rule restricts TPD to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work as required by the statute).

In reaching its conclusion, the Stone court reasoned that an injured worker's post-injury wage is evidence that, depending on the circumstances, may be of great, little, or no importance in determining whether the worker has a diminished "earning power at any kind of work" under ORS 656.212. Specifically, the Stone court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

Therefore, Stone sets forth the manner in which to calculate a worker's TPD rate and concludes that post-injury wages do not, in and of themselves, establish whether a worker has a diminished "earning power at any kind of work" pursuant to ORS 656.212. We, thus, agree with the Referee that claimant's receipt of regular wages for her modified work does not preclude a finding that claimant's injury was disabling. Because OAR 436-30-045(5)(a) and (d) equate disability with reduction in post-injury wages, they are inconsistent with the court's holding in Stone. Thus, we give those rules no effect in this case.

As our recent Order on Remand in Babette Stone, 46 Van Natta 1191 (1994), makes clear, Stone is a case that involves the calculation of the amount of TPD to which the claimant was entitled. There was no dispute in Stone as to whether the claimant was entitled to TPD; the only question was what the rate (zero or something else) of TPD should be. 46 Van Natta at 1191. Inasmuch as it did not involve the issue of whether the claimant was temporarily and partially disabled, Stone is not entirely on point.

However, we have held that where a claimant is released to modified work at or above his or her regular wages, the claimant is temporarily and partially disabled, even though the actual rate of TPD may be computed to be zero. See e.g. Kenneth W. Metzker, 45 Van Natta 1631, 1632 (1993); Valorie L. Leslie, 45 Van Natta 929 (1993), rev'd on other grounds Leslie v. U. S. Bancorp, 129 Or App 1 (1994).

The facts of this claim are similar to those in Metzker and Leslie. Claimant was restricted to modified work, albeit at her pre-injury wage. Even though her rate of TPD may be zero, the mere fact that claimant was required by the compensable injury to work at modified employment means that she was temporarily and partially disabled under the rationale of cases such as Metzker and Leslie. Thus, claimant was disabled as a result of her injury, notwithstanding the fact that she may receive TPD at the rate of zero once her TPD is calculated. Once again, we emphasize that the issue is claim classification (i.e., whether the claim is disabling), not whether temporary disability is due and payable.

In conclusion, we agree with the Referee that claimant has sustained a compensable disabling injury. We, therefore, affirm the Referee's determination on this issue.

Claimant's counsel is entitled to attorney fees for services on review concerning the claim classification issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review regarding this issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 10, 1994 is affirmed. Claimant's counsel is entitled an assessed fee of $1,000 for services on review, payable by the insurer.

August 31, 1994 Cite as 46 Van Natta 1729 (1994)

In the Matter of the Compensation of
ELVA M. McBRIDE, Claimant
WCB Case No. 93-07257
ORDER OF ABATEMENT
Bryant, Emerson, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The self-insured employer requests reconsideration of our August 8, 1994 Order on Review that concluded that claimant has established the compensability of medical services related to her low back following the November 1992 motor vehicle accident.

In order to allow sufficient time to consider the motion, we withdraw our August 8, 1994 order. Claimant is granted an opportunity to respond to the employer's motion. To be considered, that response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA J. MIOSSEC, Claimant
WCB Case No. 93-11841
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Podner's order that: (1) clarified SAIF's acceptance of claimant's psittacosis condition by deleting the word "resolved;" and (2) awarded claimant a $1,500 attorney fee for obtaining that clarification. On review, the issues are claim processing and attorney fees.

We adopt and affirm the Referee's order with the following supplementation.

Claim Processing

Claimant filed a claim for a psittacosis condition commencing May 31, 1993. SAIF accepted the claim by Notice of Acceptance on September 27, 1993. Specifically, SAIF accepted, as disabling, "psittacosis resulting from 05/31/93 exposure, resolved." (Ex. 6-1). Claimant's claim has not been closed.

Claimant requested a hearing, objecting to the word "resolved" in the Notice of Acceptance. The Referee concluded that the word "resolved" could serve to limit either current or prospective treatment for the compensable condition. Accordingly, the Referee modified SAIF's acceptance to remove the word "resolved." In addition, the Referee awarded an $1,500 attorney fee for clarifying the denial. We agree and add the following supplementation.

While SAIF asserts that its use of the word "resolved" in a Notice of Acceptance is not a denial of any condition, we agree with claimant that a notice of acceptance should not address the alleged permanency of an accepted condition. We reach this conclusion because of the procedural problems that such an acceptance can cause.

We recently addressed this issue in Gary L. Best, 46 Van Natta 1694 (1994). In Best, we held that a carrier's acceptance of a so-called "resolved" condition constituted a "de facto" prospective denial of that condition. Citing Roller v. Weyerhaeuser, 67 Or App 583, mod 68 Or App 743, rev den 297 Or 124 (1984), we determined that such an acceptance implied that the carrier was no longer responsible for future benefits for the condition. Since claim closure (accompanied by a permanent disability award) had issued simultaneously with the carrier's acceptance in Best, we did not consider the carrier's action to be an attempt to circumvent the claim closure provisions. Nevertheless, we reasoned that the carrier's acceptance of a "resolved" condition represented a denial of future responsibility relating to an accepted claim. Consequently, notwithstanding the carrier's payment of all present compensation, we held that the acceptance constituted an invalid prospective denial. See Boise Cascade Corp. v. Hasslen, 108 Or App 605, 607 (1991).

Here, SAIF accepted the claim as disabling, but also described the accepted condition as "resolved." Thus, in accordance with the Best rationale, regardless of whether all present compensation for the claim has been provided, we hold that such an acceptance constitutes a prohibited prospective denial of future benefits for the compensable condition. Evanite Fiber Corp. v. Striplin, supra.

Finally, unlike the situation in Best, claimant's claim was not closed simultaneously with SAIF's acceptance of a "resolved" condition. The "pre-closure" nature of this "de facto" denial of future responsibility for the claim provides further support for the impermissability of SAIF's claim processing decision.

Amount of Attorney Fee

SAIF argues that claimant is not entitled to an attorney fee for setting aside a prospective denial or, in the alternative, that the $1,500 fee awarded by the Referee was excessive. We disagree with SAIF's contention that an attorney fee is not permitted for setting aside a prospective denial. See Tuong Canh Kha, 42 Van Natta 1072 (1990); Thomas B. Spain, 42 Van Natta 1242 (1990).

With respect to the amount of the attorney fee, after considering the factors set forth in OAR 438-15-010(4), we find that $1,500 is a reasonable attorney fee. In particular, we have considered the complexity of the issue, the value of the interest involved, the time devoted to the issue (as represented by the record), and the risk that claimant's attorney might go uncompensated.

Attorney Fee on Board Review

SAIF argues that claimant is not entitled to an attorney fee for services on Board review because SAIF is only contesting claimant's entitlement to an attorney fee. We disagree.

Although SAIF frames the issue on review as solely entitlement to an attorney fee for claimant's attorney's efforts in gaining the deletion of the word "resolved" from the Notice of Acceptance, SAIF's entire Appellant's Brief addresses whether the word "resolved" in a Notice of Acceptance constitutes a denial. For the reasons previously discussed, such an issue does pertain to claimant's right to compensation. Inasmuch as we have concluded that the word "resolved" in a Notice of Acceptance is a prospective and/or pre-closure denial, we have found that claimant's compensation should not be disallowed or reduced. Consequently, we conclude that claimant is entitled to an attorney fee on Board review fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 20, 1994 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $800, payable by the SAIF Corporation.

In the Matter of the Compensation of
BONITA J. OLSON, Claimant
WCB Case Nos. 93-09491, 93-12319, 93-09490 & 93-12320
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of those portions of Referee Podnar's order that: (1) assessed penalties for unreasonable failure to timely pay interim compensation; (2) assessed attorney fees pursuant to ORS 656.386(1) for claimant's attorney's services prior to the issuance of the ORS 656.307 order; and (3) assessed attorney fees pursuant to ORS 656.382(1) for unreasonable claims processing, unreasonable denials, and unreasonable discovery violations. On review, the issues are penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. On May 10, 1993, claimant gave the employer an off-work authorization from Dr. Byerly, family physician. (Tr. 15).

CONCLUSIONS OF LAW AND OPINION

Penalty - Failure to Timely Pay Interim Compensation

The Referee found that SAIF was unreasonable in failing to timely pay interim compensation and assessed a penalty of 25 percent of any late paid interim compensation for SAIF's unreasonable delay in payment of compensation. We agree.

During the period in question, claimant worked for the same employer; however, the employer was insured by two separate carriers. Liberty Northwest Insurance Corporation (Liberty) provided coverage through June 30, 1992, after which time SAIF provided coverage. On May 13, 1992, Liberty accepted claimant's claim for bilateral wrist tendinitis. In May 1993, claimant sought treatment for bilateral wrist complaints and was taken off work for several days. On May 10, 1993, claimant returned to work and gave the employer a work release from her physician. No interim compensation was paid. Eventually, SAIF was appointed as the .307 paying agent and it paid claimant temporary disability compensation for the time she was released from work. At the hearing, Liberty accepted claimant's current condition.

ORS 656.262(4)(a) provides that "[t]he first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim." "Interim compensation" is a term coined by the court in Jones v. Emanuel Hospital, 280 Or 147, 151 (1977), to refer to temporary disability benefits which ORS 656.262 requires the carrier to pay to a claimant who is off work on an initial injury or aggravation claim until the carrier accepts or denies the claim. Nix v. SAIF, 80 Or App 656, 658, n.2 (1986), rev den 302 Or 158 (1987). The purposes of interim compensation are to prevent processing delays and to insure a worker's well-being during the period in which acceptance or denial of a claim is being considered. Jones v. Emanuel Hospital, supra.

At hearing and on review, SAIF argues that it was not notified about claimant's claim until it received Liberty's disclaimer of responsibility on July 20, 1993. Citing Larry K. Melton, 44 Van Natta 1145 (1992), SAIF contends that a claimant's entitlement to interim compensation begins on the date the employer or insurer has notice or knowledge of a claim, even if the claimant can prove that he or she left work due to the injury prior to that date. Thus, SAIF argues, because claimant was off work for several days in May 1993 due to a work-related condition, but SAIF was not notified about claimant's claim until July 1993, it is not responsible for the payment of any interim compensation.

We disagree with SAIF's underlying contention. Claimant notified the employer about her current claim on May 10, 1993, when she gave the employer the off-work release. An employer must report a claim to its insurer within five days after receiving notice or knowledge of the claim. ORS 656.262(3). Here, the employer treated this claim as an aggravation claim and notified Liberty rather than SAIF, the employer's current insurer. Therefore, SAIF apparently did not receive notice of claimant's claim until it received Liberty's responsibility disclaimer in July 1993. However, the employer's conduct in failing to report the claim to SAIF in a timely manner is legally attributable to SAIF. See Nix v. SAIF, supra; Steve Chambers, 42 Van Natta 524 (1990). Hence, notwithstanding the employer's conduct, SAIF is deemed to have received notice of claimant's claim on May 10, 1993.

Furthermore, if we were to allow the employer to avoid notifying its current insurer about a claim, we would be placing claims processing burdens on claimant that the statutes do not contain. ORS 656.262(1), (3).

Here, SAIF did not pay the "interim compensation" until after it was appointed the "307" paying agent, which occurred on October 20, 1993. (Ex. 30). SAIF's failure to pay interim compensation within 14 days of the employer's notice of the claim constitutes an unreasonable delay in the payment of compensation. Phillip D. Meyer, 44 Van Natta 232 (1992).

We find this conduct analogous to that in which a carrier makes untimely payments of temporary disability. Under those circumstances, we determine the "amounts then due" under ORS 656.262(10) upon which to base a penalty based on the amount of each late payment. Helen M. Chase, 42 Van Natta 1850 (1990); Catherine A. Medina, 39 Van Natta 384 (1987).

Applying that reasoning to SAIF's late payment of interim compensation, we affirm the Referee's award of a 25 percent penalty on the late paid interim compensation, to be shared equally by claimant and her attorney, in lieu of an attorney fee award for services concerning the interim compensation issue. See Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992).

Attorney Fees Pursuant to ORS 656.382(1)

The Referee awarded a fee of $2,000 for SAIF's unreasonable claim processing, unreasonable denials and unreasonable discovery violations. Although we agree that claimant is entitled to attorney fees for these unreasonable actions, we address each action separately.

In addition, we note that these unreasonable actions would ordinarily justify a penalty. However, there is no legal authority for assessing penalties totalling more than 25 percent of the compensation then due. Robert A. Brooks, Jr., 44 Van Natta 1105 (1992); Mollie E. Barrow, 43 Van Natta 617 (1991). On the other hand, the Board can award a separate attorney fee for separate unreasonable conduct that relates to a different factual basis. Martinez v. Dallas Nursing Home, supra.

Attorney Fee - "De Facto" Denial

ORS 656.262(6) provides, in pertinent part, that "[w]ritten notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim." A claim is denied "de facto" after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). See Barr v. EBI Companies, 88 Or App 132 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991).

SAIF does not dispute the fact that Dr. Byerly's work release constituted notice of a claim to the employer. However, SAIF argues that that notice was of an "aggravation" claim, which did not affect SAIF but instead affected Liberty, as the insurer with the accepted claim. SAIF argues that it had no knowledge of a "new injury" claim until it received Liberty's responsibility disclaimer on July 20, 1993. Therefore, SAIF argues, because it issued a written "Disclaimer of Responsibility and Claim Denial" on October 18, 1993, which was within the 90-day processing period, the claim was never "de facto" denied. We disagree.

As discussed above, SAIF is deemed to have had knowledge of the claim on May 10, 1993, the date claimant notified the employer. Furthermore, ORS 656.262(6) states that the statutory period begins to run from the date the employer has "notice or knowledge of the claim." (Emphasis added). No distinction is made between an aggravation claim and a new injury claim. Here, the employer had notice of the claim on May 10, 1993, and SAIF was the employer's insurer at that time. Therefore, SAIF had 90 days from May 10, 1993 to issue a written notice of acceptance or denial. It did not do so. SAIF's failure to accept or deny the claim within 90 days constitutes an unreasonable resistance to the payment of compensation.

Accordingly, claimant's attorney is entitled to a fee under ORS 656.382(1). After considering the factors set forth in OAR 438-15-010(4), we award an assessed attorney fee of $600, for SAIF's unreasonable resistance to the payment of compensation by failing to accept or deny the claim within 90 days. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

Attorney Fee - Unreasonable Compensability Denial

The Referee found that SAIF's compensability denial was unreasonable and, on that basis, assessed an attorney fee. We agree.

SAIF argues that it did not deny the compensability of claimant's claim either as a "de facto" denial or in its October 18, 1993 written denial. As discussed above, we reject SAIF's argument that it did not "de facto" deny claimant's claim. Also, we reject SAIF's argument that its October 18, 1993 written denial is limited to a denial of responsibility only. Instead, we find that SAIF also denied compensability of claimant's claim.

SAIF's October 13, 1993 denial is entitled "DISCLAIMER OF RESPONSIBILITY AND CLAIM DENIAL." (Ex. 28). In addition, the denial contains a bold-face paragraph that begins, "THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS," and included the language expressly required by OAR 438-05-053(4) in the case of a disclaimer of responsibility that is coupled with a denial of compensability.

The Court of Appeals has held that "[carriers] are bound by the express language of their denials[.]" Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993). Therefore, testimony regarding the purported meaning of a carrier's written denial is irrelevant. See id. at 351-52. Accordingly, SAIF's claims examiner's testimony that he intended to deny only responsibility for claimant's condition is irrelevant.

In addition, SAIF indicated that it had requested the designation of a paying agent pursuant to ORS 656.307. We note that an order designating a paying agent pursuant to ORS 656.307 did issue.

However, since the issuance of a "307" order does not preclude a carrier from subsequently denying compensability, we do not consider SAIF's request for designation of a paying agent (although probative evidence) to be conclusive evidence that SAIF was not contesting compensability of claimant's claim. Johnny M. Davis, 45 Van Natta 2282, n.1 (1993); Ronnie E. Taylor, 45 Van Natta 905 (1993), aff'd Taylor v. Masonry Builders, Inc., 127 Or App 230 (1994).

We conclude that, read as a whole, SAIF's denial denied the compensability of, as well as responsibility for, claimant's current condition. David J. Rowe, 46 Van Natta 1150 (1994); Johnny M. Davis, supra.

Furthermore, we find that SAIF's compensability denial was unreasonable. All medical evidence supports the fact that claimant's claim is compensable. Therefore, SAIF had no legitimate doubt as to the compensability of claimant's claim. See Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Steven R. Holmes, 45 Van Natta 330 (1993); Harold R. Borron, 44 Van Natta 1579 (1992).

In Mark Yakis, 46 Van Natta 142 (1994), we found that, at the time the non-responsible carrier rescinded its compensability denial, there was no evidence that there were any amounts then due upon which to base a penalty. Accordingly, we assessed no penalty. However, we found that an unreasonable compensability denial constitutes a resistance to payment of compensation, whether that eventual payment of compensation springs from the issuance of a "307" order or the acceptance of the claim. Therefore, we assessed an attorney fee against the non-responsible carrier for its unreasonable compensability denial.

Following that reasoning, SAIF's unreasonable denial of compensability constitutes a resistance to the payment of compensation. Accordingly, claimant's attorney is entitled to a fee under ORS 656.382(1). After considering the factors set forth in OAR 438-15-010(4), as discussed above, we award an assessed attorney fee of $700, for SAIF's unreasonable resistance to the payment of compensation by unreasonably denying compensability.

Attorney Fee - Discovery Violation

Exhibit 24C is SAIF's initial response to the Director's request for the carriers' positions regarding claimant's attorney's request for a "307" order. The Referee found that SAIF's failure to provide claimant's attorney a copy of Exhibit 24C constituted an unreasonable discovery violation, which entitled claimant to assessed attorney fees. We agree.

SAIF argues that there is no evidence that claimant's attorney did not timely receive a copy of Exhibit 24C. In support of this argument, SAIF notes that the claims examiner testified that his assistant was instructed to copy all discoverable materials, which would have included Exhibit 24C because it was dated three days before the claims examiner sent the materials to claimant's attorney. (Tr. 18-19).

Shortly after August 12, 1993, SAIF's claims examiner received a request from claimant's attorney for claims documents. (Tr. 17). However, at hearing, SAIF's attorney conceded that he received an October 12, 1993 phone call from claimant's attorney during which it was discovered that Exhibit 24C had not been copied to claimant's attorney. (Tr. 31-32, 36-37). Thereafter, SAIF sent claimant's attorney a copy of the document. Thus, we find that Exhibit 24C was not copied to claimant's attorney until approximately two months after the initial request for discovery.

OAR 438-07-015(2) requires the carrier to disclose claims documents within 15 days of initial request. In Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), the court held that failure to comply with the discovery rules can constitute an unreasonable resistance to payment of compensation under ORS 656.382(1), even when there is no evidence that the noncompliance delayed acceptance of the claim. See also Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991).

SAIF argues that, even if it did not provide timely discovery of Exhibit 24C, no attorney fees can be awarded because, no compensation was due at the time of the violation. SAIF cites Jackson, supra, in support of its argument. In Jackson, the court held that an attorney fee could not be awarded under the circumstances of that case because the employer had paid all compensation before its discovery violation. Thus, the court concluded, the employer could not unreasonably resist the payment of compensation that had been paid.

Here, however, SAIF had not paid all compensation at the time of its discovery violation. SAIF was required to provide discovery within 15 days from the initial request, which occurred shortly after August 12, 1993. (Tr. 17). Thus, discovery was due approximately August 27, 1993, and SAIF was in violation of the discovery rule after that date. In fact, discovery of Exhibit 24C was not provided until sometime in October 1993. Furthermore, interim compensation was due within 14 days after May 10, 1993, the date of the employer's notice of the claim. ORS 656.262(4)(a). However, that interim compensation was not paid until after the issuance of the .307 order on October 20, 1993. Therefore, at the time of the discovery violation, there was compensation due in the form of unpaid interim compensation.

We find that SAIF unreasonably resisted the payment of compensation by violating the discovery rules. Accordingly, claimant's attorney is entitled to a fee under ORS 656.382(1). After considering the factors set forth in OAR 438-15-010(4), as discussed above, we award an assessed attorney fee of $700, for SAIF's unreasonable resistance to the payment of compensation by its violation of the discovery rules.

Finally, we note that ORS 656.382(1) provides that, to the extent an employer has caused the insurer to be charged attorney fees, the employer may be charged with those fees.

Attorney Fee - Services Prior to Issuance of the .307 Order

Given the fact that SAIF had "de facto" denied claimant's claim by failing to accept or deny it within the statutory period and later issued a written denial of compensability as well as responsibility, the Referee found that claimant's attorney's efforts before the issuance of a .307 order were instrumental in obtaining compensation for claimant without a hearing. Therefore, the Referee awarded an attorney fee pursuant to ORS 656.386(1). We adopt the Referee's reasoning and conclusions on this issue with the following supplementation.

SAIF argues that it did not "de facto" deny claimant's claim. As discussed above, we have rejected that argument. In addition, SAIF contends that its October 13, 1993 denial was solely confined to responsibility, arguing that claimant is not entitled to an insurer-paid attorney fee under ORS 656.386(1) for a responsibility denial. See Multnomah County School Dist. v. Tigner, 113 Or App 405, 408, rev den 311 Or 150 (1991). As discussed above, we have also rejected that argument.

As a result of both the "de facto" denial and the October 18, 1993 denial, compensability remained an issue until Liberty accepted claimant's current condition at the hearing. Claimant's attorney protected claimant's interests by requesting a hearing and filing amended requests for hearing in response to SAIF's denials. On this basis, we find that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing and is entitled to an attorney fee. ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

Attorney Fee on Board Review

We note that claimant's attorney submitted a statement of services for services on Board review. However, inasmuch as penalties and attorney fees are not compensation, claimant is not entitled to an attorney fee for his successful defense of the penalty and attorney fee on Board review. State of Oregon v. Hendershott, 108 Or App 584 (1991); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated November 18, 1993, as reconsidered on January 10, 1994, is affirmed.

In the Matter of the Compensation of
ARCHIEL F. SANFORD, Claimant
WCB Case Nos. 93-10958, 93-06783 & 93-10147
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Betsy F. Byers (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Brown's order that: (1) set aside the SAIF Corporation's denial of his claim for his current low back condition; (2) upheld the self-insured employer's denial of claimant's claim for the same condition; and (3) upheld Firemans Fund's denial of claimant's claim for the same condition. On review, the issue is responsibility.

We adopt and affirm the order of the Referee, with the following supplementation.

On review, claimant argues that SAIF, the employer's first insurer, is not responsible for his current low back condition. Claimant contends that his first accepted condition in 1984 was a low back strain. Claimant argues that his low back strain was subsequently accepted in March 1991, by Scott Wetzel, as claims processor for the employer. Consequently, claimant contends that, pursuant to ORS 656.308(1), responsibility for his entire low back claim was shifted forward to Scott Wetzel.

After reviewing the record, we conclude that the medical evidence fails to establish that claimant's temporary lumbar strain in 1991 which resolved without permanent impairment, is related to his prior 1984 injury which resulted in L5 disc surgery, degenerative changes of the spine and joint pain and synovitis. Furthermore, we agree with the Referee that there is no persuasive medical evidence which relates claimant's current condition to the 1991 strain. Finally, we conclude that, under ORS 656.308(1), the persuasive medical evidence does not establish that the May 1993 injury while the employer was self-insured (while Scott Wetzel was processing the employer's claims) is the major contributing cause of claimant's current low back condition.

Under the circumstances, we agree with the Referee's conclusion that SAIF remains responsible for claimant's low back condition. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated December 29, 1993 is affirmed.

In the Matter of the Compensation of
STEVEN P. GROSSAINT, Claimant
WCB Case No. 92-07324
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Mills' order that set aside a Determination Order as prematurely issued. In his brief, claimant contends that he is entitled to penalties and attorney fees for an allegedly unreasonable denial of his psychological condition and, if his claim was not prematurely closed, he has established a compensable aggravation. On review, the issues are premature closure and penalties and attorney fees, and, if claim closure was proper, aggravation and offset. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant suffered a compensable injury to his low back on August 11, 1986 when he slipped out of his truck. (Ex. 1). The claim was accepted and claimant subsequently underwent two low back surgeries, performed by Dr. Thompson. (Exs. 3; 3A; 5A).

Claimant was evaluated at Northwest Pain Center in November 1987. The pain center physicians believed that claimant was moderately depressed secondary to his compensable injury. (Ex. 7-6). However, by the time he was released from the program, he was psychologically stable and there were no psychological recommendations. (Ex. 8-5).

Dr. Carr became claimant's treating physician in September 1988. An MRI showed moderate disc protrusions at the L4-5 and L5-S1 levels which appeared to compress the L5 and S1 nerve roots. (Ex. 10A). In June 1989, Dr. Carr believed that claimant would be a reasonable candidate for further low back surgery, but felt that claimant would have to have a significant weight loss before surgery was considered. (Ex. 9-4). Dr. Carr sent claimant to Dr. Misko for a second opinion on surgery. Id. Claimant was ultimately unsuccessful in losing weight. (Exs. 11; 15).

After seeing Dr. Misko, claimant returned to Dr. Carr in August 1989. Claimant was irritated and upset and felt that nothing was being done concerning his surgery. (Ex. 9-5). Because of claimant's mental state, Dr. Carr requested a psychological evaluation before entertaining any surgical procedures. Claimant was evaluated by Dr. Davies, a clinical psychologist, in April 1990. (Ex. 13). Dr. Davies concluded that claimant was a poor surgery risk.

In August 1990, Dr. Carr was skeptical that another surgery would help claimant and would be worth the risks involved. (Exs. 9-7; 14). Dr. Carr sought yet another opinion from Dr. Waldram. (Exs. 14; 16). Dr. Waldram recommended pursuing a conservative course of care. (Ex. 16). After receiving Dr. Waldram's report, Dr. Carr declared claimant medically stationary on October 24, 1990. (Ex. 17). Claimant was receiving vocational services but, in November 1991, it was recommended that claimant's vocational services be terminated because of noncooperative behavior. (Ex. 26).

A physical capacities evaluation was performed on July 25, 1991 which found claimant to be capable of work in the light/medium category. (Ex. 22). Claimant's claim was closed by Determination Order dated November 29, 1991 which awarded temporary total disability from August 12, 1986 through October 24, 1990 and 32 percent (102.4 degrees) unscheduled permanent disability. (Ex. 27).

In April 1992, claimant's attorney sent claimant to Dr. Dewey, a clinical psychologist, for evaluation. (Ex. 33). Dr. Dewey diagnosed depression and referred claimant to Dr. Weinstein, a psychiatrist. Dr. Weinstein indicated that he no longer took workers' compensation cases, but felt that claimant had significant depression and started him on antidepressants. (Ex. 44).

An Order on Reconsideration issued on May 27, 1992. (Ex. 38). In addition to the unscheduled permanent disability awarded by the Determination Order, the Order on Reconsideration awarded 5 percent scheduled permanent disability for the left leg and 5 percent scheduled permanent disability for the right leg. Id.

Claimant entered an on-the-job training program to become an auto parts salesperson. However, claimant was subsequently laid off. (Ex. 48-2).

Dr. Goranson, psychiatrist, evaluated claimant for SAIF. (Ex. 41). Claimant was treated by Dr. Steinhauer, a physiatrist and Dr. Duvall, a psychologist, at Pain Management Resources.

The hearing in this matter was first convened on February 26, 1993. On that date, the parties stipulated that SAIF had rescinded its denial of a psychological condition. (Ex. 56A). The hearing was postponed so SAIF could process an aggravation claim. (Tr. 7-8). Dr. Klecan, psychiatrist, performed an IME. (Ex. 58-9).

SAIF denied the aggravation claim on June 3, 1993. (Ex. 60A). On June 21, 1993, SAIF issued a notice of acceptance which accepted: "psychological condition, diagnosed as depression, resulting from the work injury of August 11, 1986, resolved." (Ex. 62).

The continued hearing reconvened, and the record was closed, on July 8, 1993.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's claim for a psychological condition was prematurely closed. We disagree.

It is claimant's burden to establish that he was not medically stationary on the date of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). Resolution of the medically stationary date is primarily a medical question resolved by competent medical evidence. Harmon v. SAIF, 54 Or 121 (1981). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, we will consider post-closure medical reports if there is no post-closure change in claimant's condition and the only question is whether claimant was medically stationary at the time of closure. Scheuning, supra.

In finding the claim prematurely closed, the Referee relied on the opinions of Drs. Carr, Steinhauer and Dewey. Dr. Dewey examined claimant on one occasion on April 9, 1992, five months after the claim was closed on November 29, 1991. (Ex. 32-13). Dr. Dewey opined that claimant was not medically stationary. However, in giving his opinion, Dr. Dewey did not address claimant's psychological condition on the date of closure. Rather, Dr. Dewey addressed claimant's medically stationary status on the date of his exam which was performed five months after closure. Moreover, at the time he performed his exam, Dr. Dewey indicated that claimant's psychological condition had changed and had worsened since the date of closure. Under such circumstances, we do not find Dr. Dewey's opinion persuasive evidence that claimant was not psychologically medically stationary on the date of closure.

For the following reasons, we also find the opinions of Drs. Carr and Steinhauer, who are not psychologists or psychiatrists, unpersuasive. Dr. Carr concurred with Dr. Dewey's opinion that claimant was not medically stationary. However, as we explained above, Dr. Dewey's report does not address claimant's condition at the time of claim closure. Moreover, we note that Dr. Carr does not consider himself qualified to give a psychological opinion and generally defers to psychiatrists because they are specialists. (Ex. 64). We likewise find Dr. Steinhauer's opinion to be unpersuasive. Dr. Steinhauer first agreed that claimant was medically stationary in November 1991 and opined that the psychological treatment he has recommended was "palliative." (Ex. 60B). Later, without explanation, Dr. Steinhauer indicated that claimant was not medically stationary. (Ex. 63). Accordingly, we do not find Dr. Steinhauer's opinion concerning claimant's medically stationary status persuasive.

Based on this record, we conclude that claimant has failed to establish that he was not psychologically medically stationary on the date of claim closure. Thus, we conclude that the Determination Order was not premature. Having determined that claimant's claim was not prematurely closed, we proceed to address the alternative issues of aggravation, extent of unscheduled permanent disability and offset.

Scope of Acceptance of Psychological Claim/Aggravation

In his brief, claimant objects to SAIF's acceptance of the psychological condition as "resolved" and argues that it amounts to a "back-up" denial. We do not find that the acceptance of the resolved condition constitutes a "back-up" denial. Nevertheless, we consider SAIF's acceptance of a so-called "resolved" condition objectionable on another ground.

We have recently held that an acceptance of a condition as "resolved" amounts to a prospective denial since it, in effect, denies future benefits in an accepted claim. Gary L. Best, 46 Van Natta 1694 (1994). A denial of future benefits in an accepted claim is invalid and of no effect. Boise Cascade v. Hasslen, 108 Or App 605, 607 (1991). Consequently, we set aside that portion of SAIF's acceptance which limited its responsibility to "resolved" depression. Gary L. Best, supra.

Given our conclusion, claimant's counsel is entitled to an attorney fee for his efforts on this issue both before the Referee and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review regarding the prospective denial is $400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate brief and the hearing record), the complexity of the issue and the value of the interest involved.

In the event that we conclude that his claim was not prematurely closed, claimant contends that he has suffered an aggravation of his accepted psychological condition. Following our review, we conclude that claimant has established a compensable aggravation.

To establish an aggravation of his compensable psychological condition, claimant must prove a worsening of his compensable condition since the last award or arrangement of compensation. ORS 656.273(1). Because claimant seeks disability compensation for a worsening of an unscheduled body part, claimant must prove that his symptoms have increased or that his underlying condition has worsened, resulting in diminished earning capacity. ORS 656.273; Smith v. SAIF, 302 Or 396 (1986); Leroy Frank, 43 Van Natta 1950 (1991). Evidence regarding the "medically stationary" condition up to and including the "last award or arrangement of compensation" that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1). Lindon E. Lewis, 46 Van Natta 237 (1994).

Here, claimant's condition allegedly worsened after the November 29, 1991 Determination Order, but before the May 27, 1992 Order on Reconsideration. Consequently, the last award or arrangement of compensation that preceded the alleged worsening was the November 29, 1991 Determination Order. Thus, in order to establish a compensable aggravation claim, claimant must prove that his compensable psychological condition worsened since the November 29, 1991 Determination Order. Lindon E. Lewis, supra.

Only Drs. Klecan and Dewey address whether claimant's compensable psychological condition has worsened. Dr. Klecan opined that there was no aggravation of claimant's psychological condition in April 1992. However, Dr. Klecan has opined that, in the course of his low back claim, claimant has never suffered any mental disorder or needed psychiatric treatment. (Ex. 58-9). Dr. Klecan's opinion is inconsistent with the law of the case which is that claimant has an accepted psychological condition. Because it is inconsistent with the law of the case, we find Dr. Klecan's opinion unpersuasive. See Kuhn v. SAIF, 73 Or App 768 (1985).

In April 1992, prior to the date of the Order on Reconsideration, Dr. Dewey opined that claimant's depression has changed since the date of the November 29, 1991 claim closure and has worsened. Specifically, Dr. Dewey has opined that claimant's "depression has worsened, his physical condition and physical conditioning have worsened, and he has been forced to depend on his father for financial survival and on his sister for emotional support, and his severe depression has remained untreated." Dr. Dewey also opined that claimant had never been adequately treated for his depression and that claimant's psychological adjustment was continuing to worsen.

Based on Dr. Dewey's opinion, we conclude that claimant's psychological condition has worsened since the November 29, 1991 Determination Order. We further conclude that claimant has established that his earning capacity has diminished as a result of his worsened condition. In this regard, we note that claimant has not received a prior award of disability for his compensable psychological condition. However, at the time he evaluated claimant, Dr. Dewey believed that claimant had significant permanent disability due to his psychological condition. Based on this opinion, we find that claimant has established a diminished earning capacity. Accordingly, based on this record, claimant has established a compensable aggravation claim.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate brief and the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

Extent of Unscheduled Permanent Disability

We conclude that the issue of the extent of claimant's permanent disability should be deferred until closure of claimant's aggravation claim. We base this conclusion on the following reasoning.

Permanent disability should not be rated if a claimant is not medically stationary at the time of the hearing or if the claim is in open status. ORS 656.268(1); Kociemba v. SAIF, 63 Or App 557 (1981); Glean A. Finley, 43 Van Natta 1442 (1991). The Board has followed this rule where the claimant was medically stationary when the claim was initially closed but the claim was open at the time of hearing or where the claimant was not medically stationary at the time of hearing because of a subsequent aggravation. See Wanda N. Hainey, 44 Van Natta 674 (1992); Glean A. Finley, supra; Raymond E. Pardee, 41 Van Natta 548 (1989).

Here, because claimant established an aggravation of his compensable psychological condition, his claim is now in open status. Thus, it would be premature to rate claimant's permanent disability and the issue of the extent of permanent disability issue should be deferred pending closure of claimant's aggravation claim. Wanda N. Hainey, supra.

Accordingly, we direct the Central Files Section of the Hearings Division to assign a new WCB case number to the extent of permanent disability issue. Litigation of this new case shall be deferred pending closure of the aggravation claim. The parties are requested to keep the Hearings Division apprised of further developments regarding closure of claimant's aggravation claim.

In the event that the closure of claimant's aggravation claim results in another hearing request, that request shall be consolidated with the new WCB case number created by Central Files concerning claimant's hearing request regarding the May 27, 1992 Order on Reconsideration. Should no subsequent hearing request be filed after the closure of claimant's aggravation claim, the parties shall notify the Hearings Division and proceed to a determination of the extent of claimant's permanent disability based on the hearing request filed on the May 27, 1992 Order on Reconsideration.

Offset

In the event that we find that the claim was not prematurely closed, SAIF asserts an overpayment of temporary disability benefits in the amount of $7,605.96 and seeks authorization to offset this amount against future permanent disability awards. (Ex. 30).

Claimant did not dispute the amount of the overpayment or the Board's authority to authorize an offset should we find that the claim was not prematurely closed. Accordingly, we authorize SAIF to recoup its overpayment of $7,605.96 against future awards of permanent disability under this claim.

Penalties and Attorney Fees

We adopt the Referee's reasoning and conclusions concerning the penalty and fee issue.

ORDER

The Referee's order dated August 4, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which set aside the Determination Order and Order on Reconsideration as premature is reversed. The Determination Order and Order on Reconsideration are reinstated. The Referee's award of an out-of-compensation attorney fee is also reversed. SAIF's June 3, 1993 aggravation denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review concerning the aggravation issue, claimant is awarded $3,000, payable by SAIF. The Central Files Section of the Hearings Division is directed to assign the extent of disability issue a new WCB case number with further action on the case to be deferred pending closure of claimant's aggravation claim. Claimant's attorney is awarded an assessed attorney fee of $400 for his efforts in clarifying SAIF's acceptance of his psychological condition. SAIF is authorized to offset overpaid temporary disability benefits of $7,605.96 against any future awards of permanent disability. The remainder of the Referee's order is affirmed.

September 1, 1994 Cite as 46 Van Natta 1741 (1994)

In the Matter of the Compensation of
FRANCIS A. SIMS III, Claimant
WCB Case Nos. 93-02067 & 92-15231
ORDER OF ABATEMENT
Malagon, Moore, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney
Meyers & Radler, Defense Attorneys

Lumbermen's Underwriting Alliance (LUA) requests reconsideration and abatement of our August 3, 1994 Order on Review. As part of that order, we: (1) determined that the SAIF Corporation remained responsible for claimant's current low back condition; (2) assessed against LUA a penalty of 25 percent of any compensation "then due" as of the date of hearing for LUA's unreasonable compensability denial; and (3) in the alternative, if there were no amounts "then due" at hearing, assessed a fee of $300 against LUA for unreasonable resistance to the payment of compensation regarding its unreasonable compensability denial. In its request, LUA asserts that our order is ambiguous and requests clarification of the assessments made in items two and three listed above.

In order to consider LUA's motion, we withdraw our August 3, 1994 order. Claimant and SAIF are granted an opportunity to respond by submitting a response within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
WALTER R. ADAMS, Claimant
WCB Case No. 92-16531
ORDER ON REVIEW
Breathouwer, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband, Gunn, and Haynes.

The insurer requests review of Referee Galton's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction and supplementation. Claimant's regular graveyard shift is from midnight to 8:30 a.m., with an unpaid lunch break from 5:00 to 5:30 a.m.

Claimant is employed by MS Management Associates, Inc. (MSM). He was hired about June 1991 to work as a custodian/housekeeper. His duties occur primarily in the Lloyd Center Mall.

The Lloyd Center properties include the mall, Halladay Market, a Safeway Store, and Shaving Service West (Shaving Service). (#1 Tr. 8, 9). All Lloyd Center properties are owned by Si-Lloyd Associates, Ltd. (Si-Lloyd).

Halladay Market, Safeway, and Shaving Service are located across Weidler Street from the main mall buildings. Shaving Service is located next to Safeway and shares part of Safeway's south wall. (Exs. 11, 12, 13). Both Safeway and Shaving Service face the mall's east parking lot. There is a sidewalk adjacent to the east parking lot which runs between the east parking lot and the Safeway and Shaving Service stores. This sidewalk is not a public sidewalk and is part of the property owned by Si-Lloyd.

On December 7, 1992, while on an unpaid lunch break, claimant slipped and fell on this sidewalk in front of Shaving Service. (#1 Tr. 38, 43, Ex. 13). The sidewalk was covered with snow at the time.

Si-Lloyd has no employees that manage its property; it contracts with MS Management Associates, Inc. (MSM) to act as its exclusive managing agent. (#1 Tr. 10, 30, 90). Whatever obligations Si-Lloyd has regarding maintenance and security of the east parking lot are accomplished through MSM. (#2 Tr. 11).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions regarding the compensability issue with the following supplementation.

In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted a unitary "work-connection" approach for assessing if the relationship between claimant's injury and employment is sufficient to render an injury compensable. Id at 642. Citing Clark v. U.S. Plywood, 288 Or 255, 260 (1980), the Court recently explained that there are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arise out of employment" tests the causal connection between the injury and the employment. Norpac Foods v. Gilmore, 318 Or 363 (1994). Both elements must be evaluated; neither is dispositive.

As a general rule, injuries sustained by employees when going to and coming from their regular workplace are not deemed to arise out of and in the course of their employment. SAIF v. Reel, 303 Or 210, 216 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). There are, however, exceptions to the general rule.

One such potential exception is the "parking lot rule." The "parking lot rule" holds that, if an injury occurs in a parking lot or other off premises area over which the employer has some control, the injury may be compensable. Control is manifested by: (1) employer ownership or maintenance, see Montgomery Ward v. Cutter, 64 Or App 759 (1983), Janet V. Dollens, 42 Van Natta 2004 (1990), aff'd mem 107 Or App 531 (1991); (2) employer actions, see Montgomery v. SAIC, 224 Or 380 (1960); or (3) the presence of employer created special hazards, see Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971).

In Norpac Foods v. Gilmore, supra, the Supreme Court recently elaborated on the "parking lot rule." The Court explained that application of this rule establishes only that the time, place, and circumstances of the injury are sufficiently work-related to satisfy the threshold "in the course of" element, but that the second element of the work-connection inquiry must also be satisfied. Thus, to prove compensability, claimant must also establish that his injury "arose out of" his employment. In other words, claimant must also establish a sufficient causal connection between his employment and the injury to prove compensability.

The insurer argues that the "parking lot rule" exception to the going and coming rule does not apply here because the record does not establish that the employer had the requisite control of the area of injury. Claimant argues that, as the exclusive managing agent for Si-Lloyd, MSM assumed Si-Lloyd's maintenance responsibilities, and thereby assumed control of the area where claimant was injured. We agree with claimant.

Here, claimant was employed as a custodian-housekeeper by MSM, which serves as the exclusive managing agent for the Lloyd Center properties, owned by Si-Lloyd. (#1 Tr. 10, 30). On December 7, 1992, while on his unpaid lunch break, claimant walked to Safeway to purchase food. It was snowing and snow had accumulated on the sidewalks. Claimant slipped and fell on the sidewalk adjacent to the east parking lot, in front of Shaving Service, and injured his low back. (#1 Tr. 38, 43, Ex. 13).

Si-Lloyd owns all of the property in the Lloyd Center complex, including the properties leased to Safeway and Shaving Service. Si-Lloyd has no employees that manage its property; instead, it contracts with MSM to act as its exclusive managing agent. (#1 Tr. 10, 30, 90). Whatever obligations Si-Lloyd has regarding maintenance and security of the east parking lot area are accomplished through MSM. (#2 Tr. 11). By this arrangement, MSM has assumed Si-Lloyd's maintenance responsibilities. Thus, within the context of the workers' compensation law, MSM has control over the area where the injury occurred as a result of these contracted maintenance responsibilities. Montgomery Ward v. Cutter, supra, Janet V. Dollens, supra.

The insurer notes that claimant did not fall in the east parking lot but, instead, fell on the sidewalk in front of Shaving Service. The insurer argues that claimant has not proved that the employer had the requisite control over the area of injury because nothing in the lease between Si-Lloyd and Shaving Service indicates who is responsible for maintenance of the sidewalk in front of Shaving Service.

The lease between Si-Lloyd and Shaving Service appears to be a standard lease between Si-Lloyd and the tenants of Lloyd Center, with most of the terms preprinted on the lease form. (Ex. OB). We note that MSM is a signatory to that lease, indicating its management authority. We agree that the lease between Si-Lloyd and Shaving Service does not indicate who is responsible for maintenance of the sidewalk in front of Shaving Service. However, that fact does not decide the control issue because the lease between Si-Lloyd and Safeway establishes that Si-Lloyd has responsibility for maintenance of the area of injury.

The lease between Si-Lloyd and Safeway provides that Si-Lloyd is responsible for keeping the east parking lot and the adjacent sidewalks in good repair. (Ex. OA-3). In addition, the lease provides that, if Safeway fails to perform any duty under the lease, Si-Lloyd has the right to perform the duty and charge Safeway for the cost of performance. (Ex. OA-4). We find that this lease establishes that Si-Lloyd has responsibility for maintenance of the area of injury, which is both adjacent to the east parking lot and adjacent to the Safeway leased property. Futhermore, as discussed above, as a result of the transfer of maintenance responsibilities from Si-Lloyd to MSM, through MSM's duties as Si-Lloyd's exclusive management agent, MSM has control of the area of injury.

Therefore, we find that the circumstances of this case come within the "parking lot rule" and that claimant has established that the time, place, and circumstances of the injury are sufficiently work-related to establish his injury arose "in the course of" employment. Norpac Foods v. Gilmore, supra.

Because MSM was responsible for maintaining the area of injury and claimant's injury was caused by the accumulation of snow, there is a sufficient causal connection between his employment and the injury to prove compensability. Therefore, claimant has also established that his injury "arose out of" his employment. Id. Accordingly, claimant's low back injury is compensable.

Attorney Fees for Services on Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 21, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid directly to claimant's attorney by the insurer.

Board Member Haynes dissenting.

I agree with the majority's statement of the law regarding the parking lot exception to the coming and going rule. However, because I find that the employer did not have control over the area of injury, I find that the parking lot exception does not apply here. Furthermore, application of the Mellis factors establishes that claimant's injury is not compensable. Therefore, I respectfully dissent.

Claimant's injury occurred on the sidewalk in front of Shaving Service West (Shaving Service) while claimant was on his unpaid lunch break. (#1 Tr. 38, 43, Ex. 13). It is important to remember that claimant's employer is MS Management Associates, Inc. (MSM), not Si-Lloyd Associates, Ltd. (Si-Lloyd). Therefore, the determination as to whether the parking lot exception applies to this case turns on whether MSM had control over the area of injury. Whether or not Si-Lloyd had control over the area of injury is irrelevant.

Furthermore, although the record indicates that there is a written agreement between MSM and Si-Lloyd, that agreement is not in the record. (#1 Tr. 11). The agreement between MSM and Si-Lloyd might have determined that MSM had control over the area of injury. However, contrary to the majority's assertions, the leases in the record, which are between Si-Lloyd and Safeway and Si-Lloyd and Shaving Service, do not determine that MSM has control over the area where the injury occurred. In fact, those leases say nothing about who has control over the sidewalk in front of Shaving Service.

Here, there is no evidence of any actions or special hazards created by MSM that would manifest its control over the area of injury. Montgomery v. SAIC, 224 Or 380 (1960); Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971). Furthermore, MSM neither owns nor leases any property in the Lloyd Center complex. Therefore, the only way MSM's control might be manifested is through maintenance of the area of injury. Montgomery Ward v. Cutter, 64 Or App 759 (1983), Janet V. Dollens, 42 Van Natta 2004 (1990), aff'd mem 107 Or App 531 (1991).

As the majority concedes, the lease between Si-Lloyd and Shaving Service does not indicate who has the duty to maintain the sidewalk in front of Shaving Service. (Ex. OB). Furthermore, the lease between Si-Lloyd and Safeway provides that Si-Lloyd is responsible for keeping the sidewalks adjacent to the premises leased by Safeway in "good repair." That lease does not address whose responsibility it is to maintain the sidewalk in front of Shaving Service. (Ex. OA-3). Therefore, neither lease addresses whose duty it is to maintain the sidewalk in front of Shaving Service, let alone assign that duty to MSM.

The majority gets around this by the following circuitous route. First, the majority finds that, since Shaving Service is next to Safeway, the sidewalk in front of Shaving Service is included in the Safeway/Si-Lloyd lease clause which refers to Si-Lloyd's duty to maintain sidewalks "adjacent to the leased premises" in "good repair." Therefore, the majority finds, Si-Lloyd has the duty to maintain the area in front of Shaving Service through its lease with Safeway. Finally, the majority concludes, MSM has assumed Si-Lloyd's duty to maintain this area through its agreement with Si-Lloyd.

The connection the majority creates is too tenuous to support a finding that MSM had control over the area of injury. Absent is the direct link to control between the employer (MSM) and the area of injury that the courts have required. Henderson v. S.D. Deacon Corp., supra (employer's lease gave the employer the right to require the landlord to repair the elevator, the area of injury); Montgomery Ward v. Malinen, 71 Or App 457 (1984) (city ordinance required the employer to keep the sidewalk where the claimant fell clear of now and ice and it was the employer's policy to do so); Montgomery Ward v. Cutter, supra (employer's lease gave the employer the right to require the mall operator to repair the hole in the parking lot where claimant was injured).

The court has held that control may be established where an employer assumes responsibility for upkeep of the area of injury, even where it has no contractual obligation to do so. Willis v. State Acc. Ins. Fund, 3 Or App 565 (1970). However, that is not the case here. There is no evidence that MSM had assumed any of the maintenance duties to the area of injury or in the Safeway/Si-Lloyd lease. Mr. Hesselink, an MSM employee who serves as the operations director of the Lloyd Center properties, testified that MSM has never provided snow removal services to the area where claimant fell and that Safeway maintains its leased premises and the east parking lot. (#1 Tr. 23, #2 Tr. 5-8).

For these reasons, I would find that MSM did not have control over the area of injury. Therefore, the exception to the going and coming rule does not apply here.

Furthermore, claimant's claim also fails the seven-factor test first set forth in Jordan v. Western Electric, 1 Or App 441 (1970). These factors are: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; and (6) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Id.

Benefit to the Employer

Claimant's activity of taking a lunch break provided some benefit, although very incidental, to the employer in the form of a more refreshed employee. Sheri V. Hiltner, 42 Van Natta 1039 (1990).

Activity contemplated by the Parties

Claimant was allowed to engage in any activity he desired at lunch, including leaving his work area. Furthermore, claimant was advised by his supervisor that he need not punch out when going to Safeway. Therefore, I find that going to Safeway for lunch was contemplated by the parties.

Ordinary Risk Incidental to Employment

There is no evidence that the employer required or encouraged claimant to leave the mall building to eat lunch. A break room in the mall building was available for claimant's use. (#1 Tr. 45). Claimant was free to do what he wanted on his lunch break. Thus, claimant was not engaged in an activity incidental to employment when he used his lunch break to walk to Safeway to purchase lunch.

Payment for the Activity

Claimant was not paid for his lunch breaks.

Activity on the Employer's Premises

As discussed above, MSM did not own, lease, or control the area of injury. Therefore, the activity did not occur on the employer's premises.

Employer Direction or Acquiescence

There is no evidence that the employer directed claimant to leave the main mall area during his lunch break. However, claimant was free to leave the area during his lunch. The employer was aware that claimant and other employees did so. Thus, the employer acquiesced to claimant leaving the main mall area during his lunch period.

Personal Mission

The Referee found that claimant was not on a personal mission when he went to Safeway on an unpaid lunch break. I disagree. Apparently, the Referee based this finding on the fact that claimant was carrying a radio with a phone patch, which enabled him to communicate with security. (#1 Tr. 35-36). Thus, claimant could be considered to be "on-call" during his lunch break.

However, being "on-call" does not take an otherwise personal mission out of the personal category, unless the "on-call" worker is actually called or his or her activity is significantly restricted. Allen v. SAIF, 29 Or App 631, rev den 280 Or 1 (1977); see also Walker v. SAIF, 28 Or App 127, 130 (1977) (court was "unwilling to forge a general exception to the going and coming rule for persons whose employment requires a uniform and on-call status").

Here, claimant's activity of going to purchase lunch on an unpaid lunch break was personal. The only circumstance that could take that activity out of the "personal" category is his "on-call" status. However, claimant was not called during his lunch break. In addition, claimant's activity was less restricted than that of the decedent in Allen, supra, in that there is no evidence that claimant was required to remain within radio range during his lunch break. (#1 Tr. 50). Instead, claimant was free to go where he wished on his lunch break, so long as he checked out if he left the Lloyd Center property. Therefore, I conclude that claimant's activity was not significantly restricted by his on-call status. On this record, I conclude that claimant was on a personal mission when he was injured.

In combination, the factors preponderate against a finding of a sufficient work connection to establish the compensability of the claim. Claimant was on a personal mission, was not being paid, was not engaged in a task incidental to work, and was not injured in an area under his employer's control. Although claimant was engaged in an activity that was contemplated by and acquiesced to by his employer, and which was of some benefit to his employer, I do not find these considerations sufficient to preponderate toward finding a sufficient work connection.

Finally, it appears that Si-Lloyd attempted to create a "paper tiger" with its agreement with MSM in an effort to protect itself against tort liability. With the majority's decision that claimant's claim is compensable, Si-Lloyd has succeeded in its attempt. Because claimant's workers' compensation claim is an exclusive remedy, claimant has no tort remedy against Si-Lloyd. ORS 656.018. Furthermore, the majority's decision unnecessarily extends the parking lot exception by not requiring some form of direct control, as the courts have required.

In the Matter of the Compensation of
JANET L. LUNDSTEN, Claimant
WCB Case No. 93-03990
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Westerband, Hall and Haynes.

Claimant requests review of Referee Quillinan's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant treated with Dr. Hughson, M.D., immediately following the April 24, 1986 work injury. On June 4, 1986, Dr. Hughson referred claimant to Dr. Hoppert, orthopedist, who has treated claimant's low back condition since that referral. Dr. Hoppert opined that the 1986 work accident: (1) injured the supportive structures at the L3-4 level of claimant's spine; and (2) is the most probable cause of claimant's current L3-4 disc herniation. (Exs. 30, 31).

The May 24, 1988 Determination Order is the last arrangement of compensation. (Ex. 18). At the time of that Determination Order, claimant was released to sedentary work eight hours a day with limits on carrying no more than ten pounds occasionally, walking, standing, sitting 20 minutes at a time, and no repetitive bending, lifting, stooping, or twisting. (Exs. 3-12, 3-13, 11A).

On July 17, 1989, SAIF issued a partial denial of an earlier aggravation claim and identified the accepted condition as "a work-related injury to [claimant's] low back." (Ex. 21).

In 1990, claimant returned to work. She was able to perform full-time, full-duty work as a deli clerk/manager until December 10, 1992, when Dr. Hoppert restricted her to modified work with a ten pound lifting limit and no repetitive bending or twisting. (Ex. 3-19). On December 15, 1992, claimant was laid off work because she was unable to perform the job with the restrictions imposed by Dr. Hoppert. (Ex. 3-19). Claimant has not been physically able to return to work. (Tr. 10).

On March 29, 1993, SAIF issued a partial denial of the current aggravation claim, identifying the accepted condition as a "lumbar strain." (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

The Referee found, and the parties do not dispute, that claimant has a worsened L3-4 condition in the form of a disc herniation at that level. However, the Referee also determined that no L3-4 condition was accepted as part of the compensable claim and that the L3-4 condition is not causally related to the 1986 work injury. We find that the L3-4 condition is causally related to the 1986 work injury.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the compensable condition. Perry v. SAIF, 307 Or 654 (1989). An aggravation has two components: causation and worsening. We must first determine whether claimant's condition is compensable. If it is compensable, then we determine whether the compensable condition has worsened. Bertha M. Gray, 44 Van Natta 810 (1992), aff'd, Gray v. SAIF, 121 Or App 217 (1993).

We find that, on the merits, claimant has established that her current L3-4 condition is compensably related to the 1986 work injury. The record contains three medical opinions regarding causation.

On March 15, 1993, Dr. Rosenbaum, neurosurgeon, examined claimant on behalf of SAIF. (Exs. 28, 34). Dr. Rosenbaum recommended against surgery for the L3-4 disc bulge, noting that it is not sufficiently large to cause spinal stenosis and is not causing radicular symptoms. He found no relationship between the L3-4 disc bulge and the 1986 work injury. He concluded that the L3-4 disc bulge was due to claimant's degenerative disc disease. Id.

On June 16, 1993, Dr. Bergquist, neurosurgeon, examined claimant on behalf of SAIF. (Ex. 32). Dr. Bergquist assumed that claimant's accepted condition was a lumbar strain and concluded that that condition had long since resolved. In addition, he concluded that the cause of claimant's current condition, which he identified as mechanical low back pain, was due to degenerative disc disease. Id.

Dr. Hoppert, orthopedist, has treated claimant since shortly after the 1986 injury and performed claimant's surgery at L5-S1. Dr. Hoppert disagreed with Dr. Rosenbaum's opinion that degenerative disc disease was the cause of claimant's current condition, although he agreed with Dr. Rosenbaum's recommendation against surgery at L3-4 at this time. (Ex. 31). Dr. Hoppert opined that claimant injured her lumbar spine at more than one level in 1986, with the supportive structures at the L3-4 level being injured in 1986 and thereby being made vulnerable to further injury. Id. He explained that, as a result, the disc bulge at L3-4 has increased over the past few years, resulting in her current condition. In addition, although recognizing that claimant had degenerative disc disease at the time of the injury, he opined that the 1986 injury was the most probable cause of claimant's current problems, given the fact that her relatively young age presented a lesser chance of progressive degenerative disc disease. Id.

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are no persuasive reasons not to defer to claimant's long-time treating orthopedist. Therefore, in reliance on Dr. Hoppert's opinion, we conclude that claimant's L3-4 condition is a compensable component of the 1986 work injury.

In order to prove a compensable aggravation, claimant must prove that her compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986; Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Finally, because claimant received a previous permanent disability award for her condition, she must establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

Claimant experienced increased symptoms in late 1992 which required her to seek medical treatment after a period of almost three years without need of medical treatment. (Exs. 3-16, 3-17). In addition, Dr. Hoppert opined that the increased size of the disc bulge at L3-4 represented a worsening of claimant's underlying condition. (Ex. 31). As discussed above, we find Dr. Hoppert's opinion persuasive. In addition, we reject Dr. Rosenbaum's opinion that the L3-4 herniation is asymptomatic and that the cause of claimant's current condition is a compensable chronic lumbosacral strain condition, which has not changed since her last claim closure.

Dr. Hoppert's opinion is more in line with the facts of the case, which show that increased symptoms lead to claimant seeking treatment after a three year period during which she needed no treatment. (Exs. 3-19, 3-20, 3-21, 31). In addition, Dr. Hoppert provides a well-reasoned opinion that claimant's work injury injured the supportive structures at L3-4 and that the disc bulge has increased, representing a worsening of her underlying condition. Therefore, based on Dr. Hoppert's opinion, we find that claimant experienced both increased symptoms and a worsening of her underlying condition.

Furthermore, we find that the increased symptoms and worsened underlying condition resulted in a diminished earning capacity. The last arrangement of compensation is a May 24, 1988 Determination Order, which awarded 30 percent unscheduled permanent disability. (Ex. 18). At the time of that Determination Order, claimant was released to sedentary work eight hours a day with limits on carrying no more than ten pounds occasionally, walking, standing, sitting 20 minutes at a time, and no repetitive bending, lifting, stooping, or twisting. (Exs. 3-12, 3-13, 11A).

In 1990, claimant returned to work. She was able to perform full-time, full-duty work as a deli clerk/manager until December 10, 1992, when Dr. Hoppert restricted her to modified work with a ten-pound lifting limit and no repetitive bending or twisting. (Ex. 3-19). On December 15, 1992, claimant was laid off work because she was unable to perform the job with the restrictions imposed by Dr. Hoppert. (Ex. 3-19). Claimant has not been physically able to return to work. (Tr. 10).

We find that this evidence shows that, following the increase in symptoms and worsened underlying condition, claimant was no longer able to perform sedentary work and her physical capacities had diminished to a minimal level. Consequently, we conclude that claimant's increased symptoms and worsened underlying condition resulted in a diminished earning capacity.

During a previous symptomatic worsening in 1989, Dr. Hoppert opined that claimant's worsening was no more than waxing and waning of claimant's compensable arachnoiditis condition, which he opined was well within the disability rating claimant had been awarded. (Exs. 3-15, -16, 20). When claimant next returned for treatment near the end of 1992, Dr. Hoppert initially opined that her increased symptoms were caused by the compensable arachnoiditis condition and opined that claimant remained medically stationary. (Exs. 3-17, -18). However, after further tests indicated an increase in the size of the L3-4 disc bulge, Dr. Hoppert opined that claimant was not medically stationary and that her condition had worsened. (Exs. 3-19, -20, 31).

We find that claimant has carried her burden of proof regarding the waxing and waning element. Although claimant has experienced periods of waxing and waning in the past that are no more than that contemplated by the previous disability award, her current increased symptoms and worsened underlying condition exceed any waxing and waning contemplated by the prior Determination Order, as evidenced by her present diminished physical capacities, as discussed above.

Therefore, we conclude that claimant has established a compensable aggravation claim.

Because we find, on the merits, that claimant has established both that the L3-4 herniation is causally related to the 1986 work injury and a compensable aggravation claim, the scope of SAIF's acceptance is not dispositive. However, we reject SAIF's contention that its acceptance was limited to a lumbar strain.

The record contains no formal, written acceptance of claimant's April 1986 back injury claim. Relying on Scott Hardy, 44 Van Natta 1749 (1992), the Referee noted that, in the absence of a formal notice of acceptance, an acknowledgment of accepted conditions made in a partial denial is sufficient to establish the conditions accepted by a carrier. Therefore, the Referee reasoned, SAIF's March 29, 1993 partial denial of claimant's current aggravation claim established that claimant's initial claim was accepted for a "lumbar strain." (Ex. 29).

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). In determining the applicable limits of a "back up" denial, the Court found that acceptance of a claim encompasses only those conditions accepted in writing. Johnson v. Spectra Physics, 303 Or 49, 58 (1987). In the present case, however, no statutorily required written notice of acceptance was ever issued. Therefore, the reasoning in Johnson v. Spectra Physics does not address the question of the scope of SAIF's acceptance in this case.

Furthermore, this case is complicated by the fact that the record contains two partial denials, each of which identifies the previously "accepted" claim differently. Whereas the March 29, 1993 aggravation denial currently at issue lists the accepted condition as a "lumbar strain," a July 17, 1989 partial denial of an earlier aggravation claim listed the accepted claim as "a work-related injury to [claimant's] low back." (Exs. 21, 29). Thus, SAIF's earlier partial denial did not limit the accepted condition to a "lumbar strain." Given these inconsistencies in the partial denials, and the fact that the record contains no formal acceptance, we do not find it appropriate to rely solely on SAIF's latest partial denial to identify what condition or conditions SAIF accepted.

It is clear from the record before us that claimant's 1986 injury claim, leading up to the current March 1993 aggravation denial, was not limited to a lumbar strain. In addition to a lumbar strain, claimant was initially diagnosed as suffering from a L5-S1 disc herniation with radiculopathy and broad based bulging discs at L3-4 and L4-5. (Exs. 2, 3). On July 9, 1987, claimant was suffering from severely increased low back pain which radiated down both legs. (Ex. 3-9). A CT myelogram revealed a significant broad based disc bulge at L5-S1, and Dr. Hoppert recommended bilateral hemilaminotomies and discectomies. Id. On July 21, 1987, claimant underwent the recommended L5-S1 surgery. (Ex. 7). SAIF paid for this treatment.

Claimant developed postoperative arachnoiditis as a consequence of her L5-S1 surgery. (Exs. 3-15, -16, 23). On July 18, 1989, a SAIF claims examiner wrote to Dr. Hoppert and acknowledged that claimant's arachnoiditis condition "could occur postoperatively and do accept the fact and will pay for any treatment related to this medical condition that has occurred as a result of the surgery." (Ex. 22).

On this record, we find that, in addition to a lumbar strain, SAIF accepted the L5-S1 condition, the L5-S1 surgery, and the arachnoiditis condition that resulted from the L5-S1 surgery. In making this finding, we realize that ORS 656.262(9) provides that "[m]erely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability[.]" (Emphasis added). However, in this case, payment for the medical services presents indicia of acceptance of the conditions for which the medical services were provided. This is especially true in light of the fact that the L5-S1 condition was present immediately after the injury, SAIF was aware of its presence, that condition required surgery, and SAIF accepted a consequential arachnoiditis condition related to that surgery. In addition, SAIF's July 17, 1989 partial denial broadly identified the accepted condition as "a work-related injury to [claimant's] low back," which could encompass the L5-S1 disc condition that existed at the time of the injury. (Ex. 21). Reviewing the whole record, we conclude that SAIF accepted the lumbar strain, the disc herniation at L5-S1, the surgery at L5-S1, and the resulting arachnoiditis condition.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 10, 1993 is reversed. The SAIF Corporation's denial of claimant's aggravation claim for a low back condition is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded an assessed fee for services at hearing and on review regarding the aggravation issue of $3,000, to be paid by SAIF.

Board Member Haynes dissenting.

On the merits, I find that there are persuasive reasons not to rely on the opinion of Dr. Hoppert, treating physician. Instead, I would rely on the well-reasoned opinion of Dr. Rosenbaum, examining neurosurgeon, and find that claimant has not established a compensable aggravation claim. Therefore, I respectfully dissent.

However, as a preliminary matter, I note that the majority's discussion regarding the scope of SAIF's acceptance is dictum. This is so both because the majority: (1) decided the case on the merits; and (2) found that SAIF "accepted" a L5-S1 condition and surgery, whereas claimant's current condition does not involve L5-S1 but, instead, involves L3-4. Ordinarily, I would not respond to such dictum; however, because the majority attempts to expand well established law regarding what constitutes an "acceptance," I feel I must respond.

In Johnson v. Spectra Physics, 303 Or 49 (1987), the Court determined whether a carrier had impermissibly issued a "back-up" denial on a claim. In making that determination, the Court had to first determine what the carrier had accepted. The fact that the Court's conclusions regarding scope of acceptance were preliminary to its decision regarding a "back-up" denial issue does not limit those conclusions to "back-up" denial situations. The Court analyzed the general requirements of an acceptance. Although applying those requirements to a "back-up" denial situation, the Court did not limit its conclusions regarding scope of acceptance to a "back-up" denial situation. Thus, the Court's conclusions regarding scope of acceptance apply to all questions regarding acceptance.

In Johnson v. Spectra Physics, supra at 58, the Court held that "an insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). An insurer's failure to respond to a claim or one aspect of a claim is neither acceptance nor denial." The Court also stated that a carrier's "knowledge or notice of a condition is not a substitute for a specific written acceptance[.]" Id. at 55. The Court found that "an insurer's silence regarding one aspect of a claim is neither acceptance nor denial of that aspect of the claim. Silence is neutral." Id.

However, the majority contends that, because no written notice of acceptance was issued here, the reasoning in Johnson v. Spectra Physics does not address the scope of SAIF's acceptance. I disagree. Moreover, SAIF v. Tull, 113 Or App 449 (1992), does not support the majority's contention that the reasoning in Johnson v. Spectra Physics does not apply here. Although SAIF v. Tull stated that whether an acceptance occurs is a question of fact, both Tull and the cases discussed in Tull involved the interpretation of some type of written documentation that could have been considered an acceptance.

Given the Court's statements, as quoted above, the reasoning in Johnson v. Spectra Physics specifically addresses the scope of SAIF's acceptance. SAIF issued no written acceptance regarding the L5-S1 condition. Furthermore, SAIF's knowledge of a condition and its silence regarding that condition is not an acceptance.

Of course, the inquiry does not end there. Where there is no written acceptance, then a factual determination must be made as to what conditions are compensable. Depending on the complexity of the case, that factual determination may or may not require medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). In this complex case, the medical evidence contemporaneous with the industrial episode dictates the scope of the insurer's acceptance.

ORS 656.262(6) requires a carrier to accept or deny a claim within a specific time limit. However, failure to accept or deny a claim within the statutory time limit does not result in the claim being deemed to have been accepted. Instead, such failure may result in a penalty. Johnson v. Spectra Physics, supra; Ellis v. McCall Insulation, 308 Or 74 (1989).

Finally, the majority relies on SAIF's payment for treatment to find that SAIF "accepted" the L5-S1 condition and the L5-S1 surgery. However, ORS 656.262(9) specifically states that providing compensation shall not be considered acceptance of a claim or an admission of liability.

As to the merits, I find that there are persuasive reasons not to rely on Dr. Hoppert's opinion that claimant's current L3-4 condition is caused by the 1986 work injury. First, Dr. Hoppert diagnosed degenerative disc disease when he initially treated claimant following the work injury. (Ex. 3-3). However, approximately seven years later, he opined that the 1986 work injury was the most probable cause of the L3-4 condition, given claimant's "fairly young age and, therefore, lesser chance of progressive disc disease." (Ex. 31). Dr. Hoppert's statement discounting any contribution from disc disease on the basis of claimant's age conflicts with his findings that claimant had degenerative disc disease at the time of the work injury. Dr. Hoppert does not explain this conflict.

Second, Dr. Hoppert acknowledges that claimant's imaging studies were normal through 1989. However, he does not explain his opinion that the supportive structures at L3-4 were probably injured by the 1986 work injury but did not reveal any injury until after 1989. (Ex. 31).

For those reasons, I find Dr. Hoppert's opinion unpersuasive. Instead, I would rely on the well-reasoned opinion of Dr. Rosenbaum and find that claimant had not established that her current L3-4 condition is compensably related to the work injury. (Exs. 28, 34). Dr. Rosenbaum opined that claimant's preexisting degenerative disc disease caused her current disc herniation. He also opined that it would be purely conjectural to presume that the L3-4 support structures were injured in 1986, given claimant's nonspecific findings that did not point to the L3-4 level and the serial diagnostic studies that found the L3-4 level benign. (Ex. 34-1).

In the Matter of the Compensation of
TODD E. MOE, Deceased, Claimant
WCB Case No. 92-15393
ORDER ON REVIEW
David C. Force, Claimant Attorney
Robert J. Thorbeck, Defense Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Hall, Westerband, and Neidig.

The decedent's beneficiary requests, and the employer cross-requests, review of Referee Black's order that upheld the SAIF Corporation's denial of her survivor's benefits claim on the basis that the decedent was not a subject Oregon worker. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

The employer is a small, family owned and operated logging company incorporated in Oregon since 1985. Warren Rowden was the president; his three sons owned the company. The sister of the decedent is married to one of the sons.

The employer contracted to perform work in Oregon until March 1992, when it accepted a contract to perform work in Montana after being informed that the Oregon company for which it had been contracting could not continue to offer the employer sufficient work. (Exs. 19A and 30). On March 16, 1992, the employer told SAIF that he was taking his Oregon employees temporarily to Montana and requested an Extraterritorial Certificate of Insurance, which SAIF issued on March 18, 1992. This certificate was submitted to the Montana Employment Relations Division, which approved coverage through October 3, 1992. (Exs. 4 and 27-1). The employer submitted an Employer's Payroll Report and paid premiums on its payroll to SAIF through September 30, 1992. (Exs. 3 and 25-2). The employer paid no payroll taxes in either Oregon or Montana. (Tr. 114; Ex. 16).

In August 1992, the employer negotiated with a Wyoming company to do work in Wyoming. (Tr. 112). On August 24, 1992, after the negotiations with the Wyoming company fell through, the employer signed a contract with another Montana company to perform work in Montana from August 24, 1992 to October 30, 1992 on the Earthquake Timber Sale. (Tr. 113; Ex. 5).

The employer's employees lived in Oregon until March 1992, when the owners, the employees and their families[1] moved to rental housing in Montana. The employer moved a large portion of its logging equipment to Montana but left other equipment in Oregon. (Tr. 110; Ex. 25-2). The employer had opened a checking account in Montana in 1991, when its owners bought Montana acreage, known as the Dry Creek property. (Tr. 110). The employer issued checks drawn on the Montana account for payroll and expenses for the Montana work. (Tr. 93; Ex. 28). The employer also maintained an Oregon bank account after March 1992. (Ex. 32).

The decedent was hired by the employer in 1989. He was employed in Oregon in January and February, 1992. (Tr. 23; Ex. 38). In January 1992, he bought an Oregon resident fishing license. On February 7, 1992, he moved in with his mother when he and his wife separated. (Ex. 14). On February 10, 1992, he closed out his Oregon bank account. (Ex. 17). He retained an Oregon driver's license and Oregon automobile insurance. (Ex. 14).

The decedent moved to Montana on March 20, 1992 along with the employer and began receiving paychecks from this employer for work in Montana in April, 1992. (Ex. 15-2; 25-2). On May 28, 1992, the decedent's wife, Brenda Moe, filed a Petition for Dissolution in which she indicated that he was not an Oregon resident. (Ex. 6-4). This petition was dismissed for want of prosecution on August 31, 1992. (Ex. 6-1).

[1] Brenda Moe, decedent's wife, did not accompany the deceased to Montana.

On September 1, 1992, the decedent wrote to his girlfriend, who resided in Brownsville, Oregon. He said, "[I]f I don't get a raise here pretty soon, I just might move there with you, and finding (sic) a better job. * * * * They have been promising me and Greg raises for 6 months and we havent (sic) seen any more money. But even if they don't I will probly (sic) stay anyways. Unless you do decide to move up here and after a few months or years we don't like it we can move." (Ex. 37).

The decedent was killed on September 2, 1992 when he fell from an overhead car unit while working as a choker setter on the Earthquake Timber Sale, St. Regis, Montana. (Ex. 7).

CONCLUSIONS OF LAW AND OPINION

The Referee found that the employer was no longer a subject Oregon employer at the time of the worker's death. The Referee concluded that, therefore, the decedent was not temporarily out of state incidental to that employment. See ORS 656.126(1). The Referee reasoned that, because Oregon work had not materialized and the employer was engaged on a second non-Oregon contract as of the date of the fatal accident, the employer had moved his business to Montana.

The decedent's beneficiary and the employer contend that the employer intended to return to Oregon at the time of the decedent's fatal injury. Alternatively, the beneficiary argues that, even if the employer had not intended to return to Oregon, the decedent himself had a reasonable expectation of returning to work in Oregon. We agree with the Referee's finding that the employer viewed its work in Montana to be temporary at the outset. However, for the following reasons, we do not agree that the employer's intent to remain temporarily out of state "evaporated" at the time it began the second contract.

Subjectivity

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of state incidental to the Oregon employment. ORS 656.126(1). In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." See Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186 (1992). Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. Power Master Inc. v. Blanchard, 103 Or App 467 (1990); Phelan v. H.S.C. Logging, Inc., 84 Or App 632, rev den 303 Or 590 (1987). The out-of-state work must be incidental to work performed in Oregon for an Oregon employer and there must be proof of an established employment relationship between the worker and this employer in Oregon before the out of state injury occurs. Steven A. Dancer, 40 Van Natta 1750 (1988). In addition, the worker must have a reasonable expectation of returning to work for the employer in Oregon. Hobson v. Oregon Dressing, Inc., 87 Or App 397 (1987); Roy L. Center, 44 Van Natta 365 (1992).

In Hobson, an Oregon corporation recruited Oregonians to dismantle its Oregon plant, move it to California and operate it. The move required about ten days. The claimant was injured while setting up the new plant in California a few days after the move. The corporation had renewed its workers' compensation coverage in Oregon after the dismantling began, but prior to the move. The insurer was informed prior to the renewal that the corporation would be employing Oregon workers in California. However, the insurer was not informed that the corporate headquarters had moved to California.

In Hobson, the pivotal fact was that the business had moved. The two owners sold their Oregon home, which was also the business headquarters, and moved to a California rental which then became the business headquarters. The employer paid payroll taxes for claimant in California. The court found that the corporation's headquarters were located in California, the former Oregon worksite was effectively inactive, and the corporation's contacts in Oregon were limited to the owner's trips into the state to negotiate future projects and consult with accountants, lawyers and financial institutions.

The court reasoned that a temporary absence from the state incidental to employment is no longer temporary where it becomes impossible for the claimant to return to employment with the Oregon employer. Thus, based on its finding that the business had moved, the court concluded that, at the time of the claimant's accident, there was no longer an Oregon employer for which the work in California could be incidental.

Here, unlike the circumstances in Hobson, the employer originally and clearly intended the move to Montana to be temporary. The record indicates that when the decedent went to Montana, he continued to work for an Oregon company that had moved some, but not all of its operations and equipment to Montana. Even though the employer issued checks drawn on its Montana bank account for payroll and expenses for the Montana contracts, it kept an active bank account in Oregon, an Oregon accountant and lawyer, and maintained an Oregon business address, telephone, automobile insurance, and supplier accounts. These facts do not indicate that the employer had permanently moved to Montana. Moreover, the employer continued to identify itself as an Oregon employer to SAIF, to whom it continued to pay premiums for workers' compensation insurance. These facts indicate that the employer intended to return to Oregon after being temporarily absent from the state.

Furthermore, although in September 1992, at the time of the decedent's death, the employer did not have an Oregon contract in hand, there is no evidence in the record that the employer had been excluded from the Oregon logging industry. There is no evidence in this record from which to conclude that this employer was prohibited from returning to Oregon as soon as an Oregon contract could be negotiated. The evidence in this record leads us to conclude that the employer temporarily left Oregon in search of work and, but for events subsequent to the decedent's death, intended to return to work in Oregon.

Finally, one of the employer's sons was killed in a logging accident in November 1992. The employer credibly testified that that event resulted in his decision to then stay in Montana. Consequently, unlike the circumstances in Hobson, the record here indicates that the employer's intent as of the date of the decedent's fatal injury in September 1992 was to return to Oregon. Therefore, we conclude that the employer was a subject Oregon employer at the time of the decedent's death and, unlike the claimant in Hobson, the decedent had a reasonable expectation of returning to Oregon to work for the employer.

The next question is whether the decedent remained a subject Oregon employee. SAIF contends that he moved to Montana, not on a temporary basis, but for the foreseeable future. We disagree.

We give little weight to Brenda Moe's conflicting characterization of her husband's move, or to other hearsay testimony regarding claimant's intentions. In addition, we find little proof of the matter in the fact that the decedent licensed his car in Montana, an action that is required by law after a car is in the state for more than 30 days. Instead, the most compelling evidence is contained in the decedent's letter to his girlfriend, written the night before he was killed, in which he indicates that he intended to stay with the employer, even though the employer's long-promised raise had not come through. There is no evidence that claimant sought employment elsewhere, either in Oregon or Montana. Consequently, we conclude that claimant remained a subject Oregon employee.

In sum, we conclude, based on the preponderance of the evidence, that the employer was a subject Oregon employer and claimant was a subject Oregon employee at the time he sustained his fatal injury. See ORS 656.005(25); 656.005(26); 656.023 and 656.027.

Estoppel

Both the decedent's beneficiary and the employer raise estoppel arguments regarding SAIF's issuance of the Guaranty Contract and the Extraterritorial Certificate of Coverage for the period in question. Because we have decided the subjectivity matter on the merits, we decline to address the estoppel arguments.

Claimant is entitled to an assessed attorney fee for prevailing on the subjectivity issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the subjectivity issue is $6,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 3, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $6,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

Board Chair Neidig dissenting.

The majority concludes that the employer was a subject employer and the decedent was a subject employee at the time of the decedent's death and that, accordingly, the beneficiary's claim for survivor's benefits is compensable. I respectfully dissent for the following reasons.

The majority finds that the employer had not moved its business to Montana at the time of the decedent's fatal accident. The facts of the case lead me to a different conclusion and, unlike the majority, I find Hobson, supra, to be on point.

In Hobson, the court found that the corporation's headquarters were located in California, the former Oregon worksite was effectively inactive, and the corporation's contacts in Oregon, which were limited to the owner's trips into the state to negotiate future projects and consult with accountants, lawyers and financial institutions, were insufficient to establish a temporary, rather than permanent, absence from Oregon.

Here, the record indicates that when the decedent moved to Montana, he moved to work for a company that had moved its operations to Montana.

As in Hobson, an Oregon corporation hired Oregonians to perform work under contract in an out-of-state location. In March 1992, the employer moved the major portion of its logging equipment, its assets, its management and its employees to Montana. Negotiation regarding future projects took place in Montana and contemplated future projects in Montana and Wyoming, not Oregon. The employer issued checks drawn on its Montana bank account for payroll and expenses.

I acknowledge that the employer maintained an Oregon address, bank account, automobile insurance, and supplier accounts. However, the bank account was effectively inactive, and no business was carried on at the Oregon address. Moreover, as in Hobson, the company's contacts in Oregon were limited to the employer's trips into the state to consult with its accountant and lawyer. In light of the significant actions taken by the employer which strongly suggest a permanent relocation to Montana, I find that these minimal contacts were insufficient to indicate that the employer did more than merely contemplate the possibility of relocating back in Oregon. Furthermore, as in Hobson, even though the employer informed SAIF that it would be employing Oregon workers temporarily in Montana, it also failed to inform SAIF that it was moving the greater portion of its equipment, its assets and its management to Montana.

I conclude that, although the record indicates that the employer may have had the desire to return to Oregon, there is no evidence that it actually intended to do so. Consequently, when the decedent was killed under a second Montana contract while working in Montana, he had no reasonable expectation of returning to Oregon to work for the employer. Therefore, at the time of the decedent's accident, I find that the employer was no longer an Oregon employer for which the decedent's work in Montana could be incidental. See Hobson, supra. Accordingly, I would affirm the Referee.

In the Matter of the Compensation of
JOHN L. O'DAY, Claimant
WCB Case No. 93-01397
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Michael V. Johnson's order which upheld the SAIF Corporation's denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In order to establish a compensable injury, claimant must prove that he sustained an injury arising out of and in the course of his employment, requiring medical services or resulting in disability. In addition, the injury must be established by medical evidence supported by objective findings. ORS 656.005(7)(a). Furthermore, if there is evidence that a compensable injury combined with a preexisting condition, the "resultant" condition is compensable only if the work injury is the major contributing cause of the disability or need for medical treatment. ORS 656.005(7)(a)(B); see Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993).

Here, the Referee found that claimant was not credible, based on evidence of claimant's deceptive conduct with respect to obtaining unemployment benefits. Considering claimant's lack of credibility, as well as the record as a whole, the Referee concluded that claimant failed to prove that an injury occurred at work on December 28, 1992. Therefore, the Referee upheld SAIF's denial. We disagree.

The Referee based his credibility finding on the substance of witnesses' testimony, rather than on their demeanor and manner of testifying. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or app 282, 285 (1987). Furthermore, even if a claimant lacks credibility with regard to certain matters, he can still meet his burden of proof if the remainder of the record supports his version of how he was injured. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984).

The record reveals that claimant, with his girlfriend's assistance, obtained unemployment benefits to which he was not entitled. Claimant explained why he delayed reporting his employment to the Employment Division. (Tr. Day 1 at 48-50). He also admitted that he was not entitled to the last two weeks of his unemployment compensation, stating he intends to repay those benefits. (Tr. Day 1 at 50, 88-89). Claimant's girlfriend explained why she reported, on claimant's behalf, facts indicating his continued eligibility for unemployment benefits. She also admitted lying to the Employment Division in response to some questions. (Tr. Day 1 at 109-11, 119-21). Thus, we find that claimant engaged in and permitted some deception in order to obtain unemployment benefits.

While we do not condone claimant's conduct, we also find that claimant's and his girlfriend's testimony at hearing regarding this conduct was relatively straightforward and believable. Compare Francisco Rodriguez, 41 Van Natta 917 (1989) (when some parts of a claimant's testimony cannot be believed, it is reasonable to question other parts of testimony).

Furthermore, claimant's deception regarding unemployment compensation, while it may have occurred during the same general time period as his alleged work injury, does not materially bear on claimant's credibility regarding the circumstances of his alleged work injury. Although claimant lied to

obtain unemployment benefits, it does not necessarily follow that he also lied regarding the circumstances of his alleged work injury.[1]

Regarding the events of December 28, 1992, we do not find any material discrepancies in claimant's descriptions of the incident and related events. Claimant, a janitor who was working alone at the time of the incident, has consistently described the onset of low back pain when he lifted a trash can which he said was considerably heavier than he expected. (See Tr. Day 1 at 19-20, 24; Exs. 1B, 2, 3, 6A-1, 7A-1). He described essentially the same circumstances of injury to his employer, Mr. Gardner, and his supervisor, Mr. Jones, as he did at hearing and to the medical providers. (See also Tr. Day 1 at 185). Accordingly, we conclude that claimant's testimony regarding the circumstances of his injury is credible.

Moreover, even if we were to discount claimant's testimony, we find that the record as a whole establishes that an injury occurred at work on December 28, 1992. Mr. Gardner's behavior immediately after the alleged incident is consistent with claimant's story that he sustained an injury at work. Mr. Gardner personally visited claimant in his home shortly after the alleged incident, in response to Mr. Jones' telephone notification. Mr. Gardner did not dispute that claimant left him a telephone message regarding the incident as well. (Tr. Day 1 at 184). On the evening of the injury, Mr. Gardner suggested claimant obtain treatment from his (Gardner's) chiropractor, and he offered to pay claimant's medical bills. (Tr. Day 1 at 186-88). There is no indication in the record that Mr. Gardner questioned whether claimant sustained an injury, or that the injury occurred at work. Indeed, Mr. Gardner made the doctor's appointment for claimant, claimant received treatment from the chiropractor recommended by Mr. Gardner, and Mr. Gardner personally checked on claimant's progress until he filed the workers' compensation claim. Under these circumstances, we find that Mr. Gardner's conduct is consistent with claimant's testimony and supports a finding that claimant sustained an injury at work on December 28, 1992.

Mr. Gardner alleged that claimant changed his stories many times, which led him to suspect fraud. (See Ex. 2). The specific discrepancy Mr. Gardner identified concerned whether claimant felt pain upon bending to lift the trash can, or while he was lifting the trash can. (Tr. Day 1 at 185-86, 198). However, this alleged "discrepancy" does not suggest to us that an injury did not occur while claimant was working on December 28, 1992. Specifically, whether claimant felt pain while bending over or upon lifting a trash can does not tip the scales one way or the other. Under either scenario an incident occurred while claimant was in the process of lifting the trash can. It appears to us from Gardner's testimony that he did not doubt that some incident occurred at work; rather, he questioned the seriousness of claimant's injury. Under these circumstances, we find no material discrepancy in this point of evidence.

Furthermore, the record of medical treatment after December 28, 1992 also supports a finding that an injury occurred. On December 30, 1992, claimant received two adjustments by the chiropractor to whom he was referred by Mr. Gardner. On January 2, 1993, the same chiropractor noted that claimant was feeling better with decrease in antalgic tilting and leg pain. (Ex. 1B).

However, the same day claimant sought treatment on his own at an urgency care clinic. He saw Dr. Schunk, who diagnosed "severe low back strain," noting that claimant was walking slowly with his left thigh flexed and his back in flexion. (Exs. 3, 3A). Claimant appeared to be in severe pain, with objective findings of an acute low back strain. (Ex. 12 at 1-3). Dr. Schunk noted some improvement over the next few visits, but on January 29, 1993, he referred claimant to an orthopedist, Dr. Boyd. (See Exs. 4A, 6A).

Dr. Boyd found signs of sciatica, including nerve irritability and claimant listing to one side. (See Exs. 6A, 6B, 8). He opined that claimant was not "faking" these findings, since the various physical examination findings were all consistent. (Ex. 11-7).

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[1] Indeed, without a felony conviction, we are ordinarily reluctant to consider or permit consideration of evidence of "bad acts" by claimant with respect to such matters as unemployment compensation, because the prejudicial effect of such evidence tends to outweigh its probative value. Rose M. LeMasters, 46 Van Natta 1553 (1994). Here, however, such evidence was offered without claimant's objection.

Based on the course of treatment after December 28, 1992, we conclude that claimant did sustain an injury on that date. Based on our finding that claimant's testimony regarding the circumstances of the injury is credible, as well as the record as a whole, we conclude that the injury occurred in the course and scope of claimant's employment. Furthermore, we conclude that claimant established the injury with medical evidence supported by objective findings. (See Exs. 11 at 7-8, 12 at 2-3). ORS 656.005(7)(a).

Finally, we turn to the question of causation. Dr. Boyd diagnosed claimant's condition as a strain superimposed on a degenerative process. (Ex. 11-2). Claimant has a history of prior back injuries, and other medical providers have found the presence of degenerative disc disease. (See Exs. 3, 7A-6). Under these circumstances, we find that claimant's work injury combined with a preexisting disease. Therefore, in order to prove the compensability of his current condition, claimant must establish that his work injury is and remains the major contributing cause of disability and need for medical treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993).

Because of the presence of degenerative disease, as well as claimant's history of prior back injuries, we find that the causation question is medically complex. Therefore, we require expert medical opinion to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Claimant's treating physicians and an examining physician offered medical opinions in this case.

Claimant's treating orthopedist, Dr. Boyd, opined that the lifting incident was the major contributing cause of claimant's disability and need for medical treatment. (Ex. 11-5). Dr. Boyd explained that claimant would not have had the sciatica symptoms, which were the primary reason for his disability and need for medical treatment, from simply a continuation of his degenerative disease; the sciatica symptoms indicated the presence of an intervening muscular strain. (Ex. 11 at 15-16). Dr. Schunk, claimant's initial treating physician, agreed with Dr. Boyd's opinion. (Ex. 12-8).

Dr. Farris, an orthopedist who conducted an independent examination at SAIF's request in April 1993, opined that the major contributing cause of claimant's current condition was his preexisting degenerative disease. He believed that the December 28, 1992 incident played only a minor role in claimant's present symptoms. (Ex. 7A-6).

When medical opinions differ, we generally give greater weight to the treating physician's opinion, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no reason not to do so here.

We find that Dr. Boyd's opinion is based on a complete and accurate history of claimant's prior back conditions, as well as on observation and treatment of his current condition. We find his opinion to be well-reasoned and based on complete information. On the other hand, Dr. Farris' opinion is less persuasive, because his opinion is based on claimant's presentation in April 1993, after his condition was no longer acute, but had begun to improve. (See Exs. 6B-3, 7A-6). Accordingly, we rely on Dr. Boyd's opinion and conclude that claimant has established that the work injury of December 28, 1992 is the major contributing cause of his current condition. See ORS 656.005(7)(a)(B).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $6,800, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, claimant's counsel's statement of services and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated October 19, 1993 is reversed. The SAIF Corporation's January 15, 1993 denial is set aside, and the claim is remanded to SAIF for processing in accordance with law. Claimant's attorney is awarded $6,800 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JODI OATNEY, Claimant
WCB Case No. 93-04633
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The self-insured employer requests review of Referee Michael V. Johnson's order which: (1) set aside the Order on Reconsideration that affirmed a Notice of Closure awarding no permanent disability for a left elbow injury; and (2) remanded the claim to the Appellate Unit for appointment of a medical arbiter. On review, the issues are claim processing and extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured her right elbow while lifting freight at work on August 18, 1992. She was treated conservatively, and her claim was accepted for a disabling right elbow strain. The claim was closed by Notice of Closure on December 14, 1992 with no permanent disability award. (Ex. 12).

On January 14, 1993, the Appellate Unit of the Department of Insurance and Finance, (now the Department of Consumer and Business Services) (hereinafter called the "Department"), received claimant's request for reconsideration of the Notice of Closure. (Ex. 15). On her reconsideration request form, claimant did not indicate an objection to the impairment findings used in rating her permanent disability. (Ex. 16).

On February 1, 1993, the employer received a copy of claimant's attorney's January 20, 1993 letter to the Department amending the request for reconsideration and requesting appointment of a medical arbiter. (Ex. 18). The Department did not receive a copy of the letter.

On January 28, 1993, the Department issued an Order on Reconsideration which affirmed the Notice of Closure. (Ex. 19). The Department did not appoint a medical arbiter to examine claimant prior to issuing its order.

On February 12, 1993, claimant's attorney wrote the Department advising that claimant had amended her reconsideration request to ask for a medical arbiter. Claimant's attorney requested that a medical arbiter be appointed and the Order on Reconsideration rescinded. (Ex. 21). By letter dated February 22, 1993, the Department responded that claimant's claim file did not contain a copy of the amended reconsideration request, and requested that both parties submit to the Department any copies of the amended reconsideration request. (Ex. 22).

Later in February 1993, both parties submitted to the Department their copies of the amended reconsideration request. (Exs. 24, 25). By letter dated March 5, 1993, the Department denied claimant's request to withdraw its Order on Reconsideration on the grounds that it never received the amended request for reconsideration; that the employer did not receive its copy of the amended request until after issuance of the Order on Reconsideration; and that the employer's copy was not accompanied by a certificate of service. (Ex. 26). Subsequently, claimant's attorney again requested abatement of the Order on Reconsideration, which was denied. (Exs. 27, 30).

CONCLUSIONS OF LAW AND OPINION

Request for Medical Arbiter

The Referee concluded that, because claimant's amended reconsideration request was received by the Department within 180 days after the Notice of Closure, the Department erred in issuing its Order on Reconsideration without appointing a medical arbiter. We disagree.

ORS 656.268 sets forth the procedures for review of claim closures and disability determinations. Those procedures provide that a party has 180 days from the mailing date of a determination order or notice of closure to request reconsideration by the Department. See ORS 656.268(4)(e), (6)(b); OAR 436-30-050(1); Robert E. Payne, Sr., 44 Van Natta 895 (1992). If the basis for objection to the determination order or notice of closure is disagreement with the impairment findings used in rating the claimant's disability, the Department must refer the claim to a medical arbiter for review. See ORS 656.268(7); OAR 436-30-050(7)(c).

The Director has promulgated administrative rules governing the Department's reconsideration procedures. OAR 436-30-050(7) provides, in pertinent part:

> "Six working days after the date the request for reconsideration is received, the request and all other appropriate information submitted by the parties shall become part of the record used in the reconsideration proceeding.
>
> (a) Evidence received subsequent to the sixth (6) working day deadline may not be considered in the reconsideration proceeding.
>
> "* * * *
>
> "(c) When a basis for the Request for Reconsideration is a disagreement with the impairment findings used in rating the worker's disability at the time of claim closure, the Director shall refer the claim to a medical arbiter or panel of arbiters. * * *.
>
> "(d) The parties may not request an arbiter examination or change their request for a single arbiter to a panel of arbiters after the sixth working day from receipt of the reconsideration request." (Emphasis supplied.)

On review, the employer argues that claimant's request for a medical arbiter was untimely under the Director's rules. Claimant responds that her request for an arbiter was timely because it was mailed within six days from the Department's receipt of her reconsideration request. We disagree with claimant's reasoning.

OAR 436-30-050(7) provides that any "appropriate information" submitted by the parties on reconsideration must be received by the Department within six working days after receipt of the reconsideration request. Subsection (a) further provides that any evidence submitted by the parties and received by the Department after the sixth working day may not be considered on reconsideration.

Although, as claimant contends, subsection (d) of OAR 436-30-050(7) does not explicitly state that a request for an arbiter examination must also be received within six working days after receipt of the reconsideration request, we believe that interpretation is most consistent with the text and context of the rule. OAR 436-30-050(7) generally ensures that all "appropriate information" submitted by the parties is in the record and ready for reconsideration by the end of the sixth working day following receipt of the reconsideration request. The rule clearly contemplates that, by the seventh working day following receipt of the reconsideration request, the Department may commence its reconsideration procedure. Hence, the rule promotes expeditious reconsideration of claims based on complete evidentiary records.

For example, in addition to the aforementioned portions of OAR 436-30-050(7), OAR 436-30-050(22) provides:

> "The Department will either mail an Order on Reconsideration within 18 working days after the date the reconsideration request was received or it will notify the parties that the reconsideration proceeding is postponed for not more than 60 additional days in accordance with the provisions of ORS 656.268(5) and/or 656.268(6)(a)."

Moreover, if the Department fails to mail an Order on Reconsideration or a Notice of Postponement within 18 working days, the reconsideration request is automatically deemed denied. ORS 656.268(6)(a); OAR 436-30-050(23). In providing that the reconsideration request is deemed denied if not processed within 18 days, ORS 656.268(6)(a) and the rule demonstrate that "speedy processing and resolution of claims is a primary goal of the statute." Benzinger and Harris v. Oregon Department of Insurance & Finance, 129 Or App 263 (1994); Pacheco-Gonzalez v. SAIF, 123 Or App 312, 317 (1993).

We believe claimant's interpretation of OAR 436-30-050(7)(d) would frustrate the clear intent of the statute and the rule. Under her interpretation, the Department would be required to hold the evidentiary record open for an arbiter request which was mailed within six working days after the reconsideration request. Inasmuch as the Department could not know whether an arbiter request was mailed within the six-day period until it receives the request, the ultimate result of claimant's interpretation would be to delay the reconsideration of potentially all claims, including those where an arbiter is not requested. For these reasons, we decline to adopt claimant's interpretation. Instead, we interpret OAR 436-30-050(7)(d) to require that an arbiter request be received by the Department within six working days following receipt of the reconsideration request.

Here, we find no persuasive evidence that claimant's request for an arbiter was received by the Department within six working days following receipt of claimant's reconsideration request on January 14, 1993. In this regard, we disagree with the Referee's conclusion that timely receipt of the arbiter request can be presumed under ORS 40.135(1)(q), which provides a presumption that "[a] letter duly directed and mailed was received in the regular course of the mail." Although claimant's letter requesting an arbiter was dated January 20, 1993, there is no persuasive evidence that the letter was mailed on that date. See Madewell v. Salvation Army, 49 Or App 713, 716 (1980). Absent such evidence, we do not find the statutory presumption helpful in proving timely receipt of the letter.

Notably, it is doubtful whether the Department could have mailed notice of appointment of an arbiter within the proscribed 18-day period. The Department received claimant's request for reconsideration on January 14, 1993. (Ex. 15). Consequently, the 18 day time frame to amend that request elapsed no later than February 10, 1994. Since the Department was not in receipt of claimant's amended reconsideration request until February 12, 1993, (Ex. 21), the Department no longer had the authority to act on that request. OAR 436-30-050(23). Therefore, claimant's request to appoint a medical arbiter was not within the purview of the Department at the time of receipt.

The Referee also concluded that claimant's amended request for reconsideration was timely under ORS 656.268 because the Department was ultimately notified of the amended request within 180 days after issuance of the Notice of Closure. The Referee declined to apply the six-day limitation in OAR 436-30-050(7), reasoning that application of the rule would conflict with ORS 656.268. We disagree.

ORS 656.268 provides that a party has 180 days from the mailing date of a notice of closure to request reconsideration by the Department. See ORS 656.268(4)(e), (6)(b); OAR 436-30-050(1); Robert E. Payne, Sr., supra. The statute is silent concerning amendments to the reconsideration request, nor does it set forth any time period for requesting a medical arbiter. Under these circumstances, we find no conflict between the statute and OAR 436-30-050(7). Rather, we find that the rule is reasonably required for the administration of the Department's reconsideration procedure. See ORS 656.726(3)(a).

Moreover, the Department's Order on Reconsideration was issued on January 28, 1993. (Ex. 19). Claimant's amended request for reconsideration was not received until February 12, 1993. (Ex. 21). Inasmuch as the Department issued its Order on Reconsideration before it received claimant's amended request for reconsideration, the question is whether the Department was required to rescind its order and issue a new one at the request of either party. We find no such statutory authority or direction. The only exceptions arise when: (1) there is evidence that additional documents were not provided by the opposing party in accordance with the rule; or (2) for the correction of inadvertent errors or omissions brought to the Department's attention before a hearing is requested. OAR 436-30-050(5)(e); OAR 436-30-008(1).

Here, there is neither a dispute regarding the discovery of all documents relevant to this claim, nor do the parties raise the issue of inadvertent error or omission. Accordingly, once the Order on Reconsideration issued, neither party had the right to have that order reconsidered again by the Department. Instead, the rule provides that the Order on Reconsideration is final and any further review is properly before the Hearings Division. OAR 436-30-050(26)(c); see also ORS 656.283.

It is undisputed that claimant filed a reconsideration request with the Department within 180 days after issuance of the Notice of Closure. Hence, the Department properly had jurisdiction to reconsider the Notice of Closure. However, because claimant neither objected to the impairment findings used in rating her claim nor timely requested a medical arbiter pursuant to the Department's rules, we conclude that the Department was not required to refer her claim to an arbiter. Accordingly, the Department's Order on Reconsideration was validly issued, and should not have been set aside by the Referee.

Extent of Permanent Disability

Inasmuch as the Order on Reconsideration was validly issued, the Referee should not have remanded the claim to the Department, but instead, should have evaluated the extent of claimant's permanent disability based on the record developed at hearing. The parties presented their evidence regarding the extent issue at hearing; therefore, we find that the record is sufficiently developed for our review of the extent issue. Accordingly, we need not remand this claim to the Referee.

On the merits, Dr. Kadwell, claimant's attending physician, opined on November 24, 1992 that claimant sustained no permanent physical impairment as a result of the compensable right elbow injury. (Ex. 9). There is no persuasive medical opinion to the contrary. Accordingly, claimant is not entitled to any permanent disability award for the compensable injury.

ORDER

The Referee's order dated July 21, 1993 is reversed. The January 28, 1993 Order on Reconsideration is reinstated and affirmed in its entirety.

In the Matter of the Compensation of
STEPHEN M. OLEFSON, Claimant
WCB Case Nos. 93-03295, 93-03296 & 92-06279
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Neal's order which declined to award an attorney fee for claimant's counsel's services at a hearing concerning claimant's hearing request from a Director's subjectivity determination. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant was injured on August 5, 1990 while allegedly working for at least one of three employers who were involved in filming a movie.

On November 13, 1991, claimant filed a claim against Rocky Mountain Motion Pictures. The Department of Consumer and Business Services (Department) investigated and issued a February 3, 1992 determination concluding that claimant was not a subject worker for Rocky Mountain. (Ex. 3). Claimant requested a hearing.

On August 31, 1992, claimant filed claims against Rose and Ruby Productions and Movie Store Entertainment. The Department investigated and issued notices informing claimant that his claims could not be processed because the Department was unable to determine whether claimant was a subject worker of either employer at the time of his injury. (Exs. 9, 10). Claimant requested hearings from each of the notices.

The Referee concluded that claimant was a subject worker for Movie Store Entertainment, a subject employer. The Referee initially awarded an attorney fee pursuant to ORS 656.386. However, following the Department's objection to that award, the Referee issued an amended order eliminating the attorney fee award.

On March 25, 1994, the Department issued a Proposed and Final Order of Noncompliance of Movie Store Entertainment for the period from August 5, 1990 to August 6, 1990.

CONCLUSIONS OF LAW AND OPINION

Claimant first seeks an attorney fee under ORS 656.386(1). That statute is not applicable. An assessed attorney fee may be awarded pursuant to ORS 656.386(1) when a claimant finally prevails over a denial of compensability of a claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988); see also O'Neal v. Tewell, 119 Or App 329 (1993); Gloria J. Shelton, 44 Van Natta 2232 (1992). Here, the hearing did not pertain to compensability or address the merits of compensability of a claim. Rather, the hearing solely addressed whether claimant was a subject worker at the time of his injury. Consequently, claimant is not entitled to an attorney fee under ORS 656.386(1). Michael A. Haggenson, 45 Van Natta 2323 (1993).

Claimant next contends that, because there was the possibility that he was employed by one of three employers and one of the employers was found "responsible," he is entitled to an attorney fee under ORS 656.307(5) for meaningfully participating in the hearing. We disagree.

As stated above, the issue at hearing was which, if any, of the employers was a subject employer with regard to claimant. The hearing was not an arbitration proceeding in which the issue of responsibility between employers for a compensable condition was addressed. Inasmuch as ORS 656.307(5) expressly pertains to arbitration proceedings and because this hearing did not involve such a proceeding, we conclude that claimant is not entitled to an attorney fee under that statute.

Claimant next contends that he is entitled to an attorney fee under ORS 656.054. This statute pertains to the issuance of orders of noncompliance, and the SAIF Corporation's processing of a claim on behalf of a noncomplying employer (NCE). Here, no NCE order had issued at the time of hearing. Therefore, as with the other statutes, this particular statute is likewise not applicable.

ORS 656.054(1) provides in part:

> "If an order becomes final holding the claim to be compensable, the [noncomplying] employer is liable for all costs imposed by this chapter, including reasonable attorney fees to be paid to the worker's attorney for services rendered in connection with the employer's objection to the claim." (Emphasis added).

The Referee did not find claimant's injury claim to be compensable. Instead, the Referee determined that claimant was a subject worker for Movie Store Entertainment, a subject employer. As a result, the Department has subsequently found Movie Store to be a noncomplying employer.[1] Nevertheless, as previously noted, compensability of claimant's injury claim was not at issue at the hearing in this case. Therefore, an attorney fee under ORS 656.054 is not appropriate.

Claimant next seeks an attorney fee under ORS 656.382(1). To begin, because claimant did not raise unreasonable conduct as an issue at the hearing, we are not inclined to consider it on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). In any event, the record does not support a finding that Movie Store unreasonably resisted the payment of compensation. Such a conclusion is particularly supported by the Department's inability to determine that claimant was a subject worker for Movie Store. (Ex. 9-2).

Finaliy, claimant contends that, if an attorney fee is not appropriate pursuant to the abovementioned statutes, he should receive an attorney fee paid from claimant's award of compensation under ORS 656.386(2).

As previously noted, claimant's claim for compensation has not yet been denied. Nevertheless, it is possible that, if the Director's order of noncompliance of Movie Store Entertainment becomes final, the SAIF Corporation, as statutory claims processor, may accept claimant's claim. See ORS 656.054. If that is the case, claimant's attorney's efforts at this subjectivity hearing will have ultimately resulted in the payment of compensation to claimant. In light of such circumstances, we conclude that claimant's attorney is entitled to an "out-of-compensation" attorney fee payable from the compensation, if any, that eventually results from the Referee's order. This fee shall equal 25 percent of the increased temporary disability, if any, eventually resulting from this order, not to exceed $1,050. See OAR 438-15-045.

ORDER

The Referee's order dated December 23, 1993, as amended January 3, 1994 and January 4, 1994, is modified. Claimant's counsel is awarded 25 percent of the temporary disability, if any, eventually resulting from the Referee's order, not to exceed $1,050, payable directly to claimant's counsel.

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[1] Claimant seeks remand for the consideration of an attorney fee award as a result of the Department's subsequent NCE order. We decline to grant his request. An award under ORS 656.054 is premised on a successful defense to an NCE's challenge to the compensability of a claim being processed by SAIF. As previously explained, this case does not arise from that statute. If the NCE subsequently challenges the compensability of claimant's injury claim, and if the claim is eventually finally held to be compensable, the statute would become applicable. Should such circumstances arise in that later case, claimant could seek an attorney fee for his counsel's efforts in that proceeding. However, remanding this case for that potentiality would not be appropriate.

In the Matter of the Compensation of
MARVIN E. ROBB, Claimant
WCB Case No. 93-05343
ORDER ON REVIEW
Peter J. Carini, Claimant Attorney
Kari Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Westerband.

The SAIF Corporation requests review of Referee Black's order that awarded claimant's attorney a penalty-related attorney fee under ORS 656.382(1) for an allegedly unreasonable denial. In its brief, SAIF contends that the sole issue raised at hearing was penalties for a single act of misconduct. On this basis, SAIF contends that exclusive jurisdiction over this matter lies with the Director. In his brief, claimant asserts that, in addition to the penalty issue, an issue of failure to comply with the discovery rules was also raised at hearing. Claimant seeks a penalty-related attorney fee for the alleged discovery violation. In addition, claimant contends that he is entitled to an attorney fee pursuant to ORS 656.386(1) for obtaining compensation without a hearing. On review, the issues are jurisdiction, penalties and attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF initially denied claimant's claim for a left inguinal hernia on April 3, 1993. After receiving additional medical information, SAIF rescinded its denial on May 3, 1993.

The Referee found that SAIF's denial of claimant's left inguinal hernia claim was unreasonable and he awarded claimant's attorney a penalty-related attorney fee pursuant to ORS 656.382(1).

On Board review, SAIF contends that the sole issue raised at hearing was penalties and attorney fees for a single act of misconduct. On this basis, SAIF contends that jurisdiction over this matter rests with the Director. Claimant argues that the alleged discovery violation and the unreasonable denial are two separate acts of misconduct which could form the basis for penalties and fees. On this basis, claimant contends that the Board has jurisdiction. Claimant also contends that he is entitled to an attorney fee pursuant to ORS 656.386(1) for obtaining compensation without a hearing.

We first address claimant's contention that he is entitled to an attorney fee pursuant to ORS 656.386(1). A referee's scope of review is limited to issues raised by the parties. Michael R. Petkovich, 34 Van Natta 98 (1982). Here, the only issues raised at the hearing were penalties for an unreasonable denial and a discovery violation. (Tr. 2). Inasmuch as claimant did not raise the issue of an attorney fee pursuant to ORS 656.386(1) at hearing, we decline to address that issue. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Jurisdiction

At hearing, claimant sought penalties and fees pursuant to ORS 656.262(10) and 656.382(1) for: (1) a discovery violation; and (2) an allegedly unreasonable denial. Thus, claimant raised two separate acts of alleged unreasonable conduct which would independently support awards of penalties and/or attorney fees. Under such circumstances, we have jurisdiction over the hearing request. Corona v. Pacific Resource Recycling, 125 Or App 47 (1993); Ronald A. Stock, 43 Van Natta 1889 (1991) (Board has jurisdiction where the hearing request raises a separate attorney fee as the sole issue or alleges different acts of unreasonable conduct which would support both an ORS 656.382(1) fee and a penalty pursuant to ORS 656.262(10)). Thus, because claimant raised two separate acts of unreasonable conduct, we have jurisdiction over claimant's hearing request.

Unreasonable Denial

We adopt the Referee's reasoning and conclusion that SAIF's April 13, 1993 denial was unreasonable with the following supplementation and modification.

In 1990, ORS 656.262(6) was amended to allow insurers and self-insured employers 90 days, as opposed to 60 days, to accept or deny a claim for compensation. In Kenneth A. Foster, 44 Van Natta 148 (1992), aff'd mem, SAIF v. Foster, 117 Or App 543 (1993), we noted that the legislature's intent in amending the statute was to allow insurers and self-insured employers to conduct a more thorough investigation before making a decision to accept or deny a claim. It was hoped that the additional 30 days would help reduce the number of precipitous denials.

Here, SAIF received claimant's claim on March 11, 1993 and issued its denial on April 13, 1993. (Exs. 4; 10). In issuing its denial, SAIF relied on a March 30, 1993 letter from Dr. Brossart. Interpreted in a manner most favorable to SAIF, Dr. Brossart's opinion is, at best, ambiguous and required further explanation. Interpreted in the light least favorable to SAIF, Dr. Brossart's opinion supported compensability. Moreover, before issuing its denial, SAIF had sought Dr. Moore's opinion concerning the cause of claimant's hernia. Dr. Moore was claimant's treating physician and had also treated claimant in 1990 for the alleged preexisting condition that was the basis of SAIF's denial. Instead of waiting for Dr. Moore's response, SAIF issued its denial on April 13, 1993. SAIF received Dr. Moore's response, which supported compensability, on April 14, 1993, one day after issuing the denial. (Tr. 16). SAIF rescinded its denial on May 3, 1993 after receiving Dr. Brossart's April 22, 1993 clarification of his earlier opinion.

We conclude that SAIF rushed to judgment on the medical question. Its denial was precipitous and unreasonable. Kenneth A. Foster, supra.

Should we find that the denial was unreasonable, SAIF contends that the Referee should have awarded a penalty pursuant to ORS 656.262(10) rather than a penalty-related fee under ORS 656.382(1). We agree.

Concluding that there were no amounts then due on the date of hearing, the Referee awarded claimant's attorney a penalty-related attorney fee pursuant to ORS 656.382(1). On review, SAIF argues that the appropriate time to determine whether there are amounts then due on which to base a penalty is on the date of rescission of the denial rather than the date of hearing. We agree.

Where a compensability denial is rescinded prior to hearing, the critical period for determining whether an amount is "then due" on which to base a penalty is the time of the rescission. See Conagra, Inc. v. Jeffries, 118 Or App 373 (1993) (if it is subsequently determined that a claim was improperly denied, any benefits that become due as a result of the setting aside the denial are considered to be due as of the date the denial is set aside); see also Mark Yakis, 46 Van Natta 142 (1994); George Goddard, 45 Van Natta 557 (1993) (on reconsideration); Linda M. Akins, 44 Van Natta 108 (1992).

Here, at the time the denial was rescinded on May 3, 1993, claimant had undergone surgery and had incurred time loss. In its appellant's brief, SAIF concedes that it did not pay claimant's medical bills or time loss benefits prior to rescinding its denial. (Exs. 4; 6). Thus, on the basis of SAIF's concession, we conclude that there were amounts then due upon which to base a penalty under ORS 656.262(10). Accordingly, a 25 percent penalty will be assessed based on the amounts then due on the date of SAIF's rescission of its denial. One half of the penalty shall be paid to claimant and the other half shall be paid to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10)(a).

We distinguish the present case from Warren D. Battle, 45 Van Natta 1169 (1993). In Battle, we assessed a penalty for the insurer's unreasonable unilateral termination of temporary disability compensation. In assessing the penalty, we determined amounts then due on the date of the hearing. We find Battle distinguishable on two grounds. First, Battle involved a unilateral termination of temporary disability rather than a pre-hearing rescission of a denial. Second, the insurer did not resume temporary disability payments prior to hearing whereas, in the present case, the insurer had rescinded its denial and had begun paying benefits prior to hearing. Had the insurer in Battle paid the terminated temporary disability prior to hearing, the penalty would be based on temporary disability owing at that time. Accordingly, Battle is distinguishable from the present case.

We note that claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Discovery Violation

At the hearing, claimant raised the issue of attorney fees for a discovery violation. Specifically, claimant alleges that SAIF failed to disclose a tape of claimant's statement to SAIF's investigator. The record contains the investigator's written report which indicates that a tape recorded statement of the claimant was taken. (Ex. 8A-7). In addition, claimant testified that his interview with the investigator was taped. (Tr. 10-11).

Claimant seeks an attorney fee pursuant to ORS 656.382(1) for the discovery violation. Failure to provide discovery can interfere with the payment of compensation and can constitute an unreasonable resistance to the payment of compensation. Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991).

Here, however, we are not persuaded that the alleged discovery violation constituted unreasonable resistance to the payment of compensation. In this regard, claimant's first request for discovery occurred in his April 28, 1993 request for hearing. OAR 438-07-015(2) requires compliance with discovery requests within 15 days. SAIF rescinded its denial on May 3, 1993. Thus, by the time the discovery violation occurred, SAIF had rescinded its denial and accepted the claim. The record contains no evidence that any compensation remained unpaid at the time of the discovery violation. Under such circumstances, there was no unreasonable resistance to the payment of compensation. See SAIF v. Condon, 119 Or App 194 (1993); Aetna Casualty Co. v. Jackson, supra (No unreasonable resistance to the payment of compensation where all compensation had been paid at the time of the discovery violation).

ORDER

The Referee's order dated August 30, 1993, as reconsidered on December 28, 1993, is modified. In lieu of the Referee's award of a $1,500 penalty-related attorney fee, claimant is awarded a penalty equal to 25 percent of the compensation due as of May 3, 1993, the date of rescission of the denial, payable by SAIF. This penalty shall be paid in equal shares to claimant and his attorney.

September 2, 1994 Cite as 46 Van Natta 1766 (1994)

In the Matter of the Compensation of
KATHLEEN M. SINES, Claimant
WCB Case No. 93-09459
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Hazelett's order which upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability.

We adopt and affirm the Referee's order. In doing so, we add the following comment.

On May 5, 1993, claimant experienced low back pain while participating in a physical capacities examination at her employer's request. The examination was performed to determine whether claimant remained medically restricted from working mandatory overtime due to a preexisting, noncompensable low back condition. The examination was not performed in connection with a workers' compensation claim. Therefore, our reasoning and decision in Charles D. Stephens, 46 Van Natta 1493 (1994) (claimant sustained separate low back injury in the course of an IME examination for a shoulder injury claim) is not applicable here.

ORDER

The Referee's order dated November 30, 1993 is affirmed.

In the Matter of the Compensation of
JEFFREY B. TREVITTS, Claimant
WCB Case No. 92-13272
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Galton's order that: (1) found that the Hearings Division did not have jurisdiction over a dispute involving the effect of an approved claim disposition agreement (CDA); and alternatively, (2) held that claimant was not entitled to further "non-medical service" benefits as a result of the CDA. The self-insured employer's prior claims processor, Continental Loss Adjusting Services (Continental) requests review of that portion of the Referee's order which held that Continental was not a party to the proceeding. On review, the issues are standing, jurisdiction, and compensability. We hold that the Hearings Division has jurisdiction over this dispute, and affirm the Referee's determination concerning claimant's entitlement to additional benefits.

Unless authorized by the Board, supplemental briefs are not considered on review. OAR 438-11-020(2); Betty L. Juneau, 38 Van Natta 553 (1986). Here, however, the Board requested and considered supplemental briefing pertaining to the scope of the claim disposition agreement (CDA) at issue in this case.

Furthermore, the Board will not ordinarily entertain oral argument. OAR 438-11-015(2). However, because this case presented an issue of first impression which could have a substantial impact on the workers' compensation system, the Board determined that oral arguments were an appropriate method of assisting the members in conducting their review. See Ruben G. Rothe, 44 Van Natta 369 (1992). Consequently, on June 29, 1994, recorded oral arguments were heard by the Board en banc. After considering those arguments and the parties' appellate briefs, the Board issues the following decision.

PRELIMINARY MATTER

During opening remarks, claimant's counsel objected to an amicus curiae brief submitted by Liberty Northwest. Claimant requested that the brief be stricken, as it was not submitted within the time limits provided in the Board's letter announcing oral arguments and a supplemental briefing schedule (including amicus curiae briefs).

In accordance with the Board's announcements, briefs in this matter were to be filed with the Board on or before June 15, 1994. Liberty's brief was not received until June 27, 1994. In its brief, Liberty acknowledges that the deadline for filing had passed; however, Liberty contends that its brief should be considered based on lack of "general notice."

Pursuant to the Board's prior announcement, amicus briefs would be accepted, provided that they were filed by June 15, 1994. The parties were further advised that it was up to them to notify their respective organizations. With the exception of Liberty's brief, the remaining amicus briefs were timely filed. Under such circumstances, we conclude that Liberty's statement concerning lack of "general notice" in this matter does not constitute extraordinary circumstances for which an extension may be considered. Therefore, we grant claimant's motion to strike Liberty's amicus brief. Accordingly, we do not consider Liberty's brief on Board review.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the following supplementation.

Claimant sustained a compensable injury on August 15, 1989. His 801 claim form listed the affected body part and nature of the injury as "back" and "strain/sprain." On September 14, 1989, on behalf of the employer, Continental accepted claimant's disabling low back sprain/strain by checking the accepted disability injury boxes on the 801 form.

X-rays detected minimal L4-5 degenerative disc disease and retrolisthesis at L5. Claimant underwent surgery in November 1989 at the L4-5 level.

An MRI taken in July 1990 showed a small herniation at the L5-S1 level. Distortion of the left S1 nerve root was also detected. Based on this information, Dr. Brett, claimant's attending surgeon, concluded that claimant was suffering a pathologic worsening related to his work injury. In light of this worsening, Dr. Brett concluded that claimant was not medically stationary and would have increased permanent disability.

On September 12, 1990, Dr. Brett found that claimant was medically stationary. Claimant's permanent disability was rated as moderate subject to repetitive lifting, bending, stooping, sitting, standing restrictions.

In early 1991, claimant's former attorney began negotiating a CDA with Continental. In February 1991, claimant's former attorney sent a letter confirming a settlement offer to Continental. Specifically, in return for $30,000, claimant would accept an "immediate CDA (no more time loss, vocational assistance, permanent disability, etc.)" In March 1991, vocational assistance was terminated. Claimant's vocational consultant noted that Continental had notified him that claimant had settled his case. Claimant's former attorney drafted the CDA and a cover letter addressed to claimant, which was signed by the insurer. In an April 1991 letter to Continental which accompanied these materials, claimant's former attorney confirmed that Continental would continue to pay time loss until Board approval of the CDA. Claimant's former attorney further stated that this time loss was not subject to offset. Finally, claimant's former attorney repeated that claimant would be withdrawing his hearing request on a TTD/rate issue.

By the aforementioned cover letter, claimant was advised by his then-attorney that, in exchange for the CDA consideration amount, he would "give up or 'release'" his rights to claim closure, disability rating, an award for permanent partial disability, monthly payments for permanent total disability, vocational assistance, and future time loss benefits. The letter also stated that the only benefit claimant would not release was his right to medical services for "the accepted condition."

On May 21, 1991, the Board approved the parties' CDA. The CDA listed the claim number and the injury date which pertained to claimant's August 1989 injury claim. The CDA further provided that the accepted conditions subject to the agreement were "lumbar sprain/strain, and L4-5 disk protrusion." The CDA also provided, in part:

> "Pursuant to ORS 656.236, in consideration of the payment of $25,000 by the insurer, claimant releases his right to the following workers' compensation benefits: temporary disability, permanent disability, vocational rehabilitation and survivor's benefits, and all other benefits except for medical services. The insurer's obligation to provide these benefits is also released."

The CDA also stated that "[c]laimant retains his right to medical services for the compensable injury."

On December 4, 1991, Dr. Brett, claimant's treating doctor, received authorization from Continental to perform surgery at the L5-S1 level. Following surgery, Continental paid claimant's medical and hospital bills.

After execution of the CDA and performance of the surgery, claimant retained new counsel. On August 24, 1992, claimant's new attorney sought payment of temporary total disability benefits for disability due to the L5-S1 surgery. The employer's current claims processing agent, Sedgwick James, declined to pay benefits on the ground that by the CDA claimant had released his rights to benefits on the claim other than medical services.

CONCLUSIONS OF LAW AND OPINION

Standing

As a preliminary matter, we first address Continental's challenge to the Referee's holding that, as a prior claims processing agent, Continental was not a party and would not be permitted to participate at hearing.

We agree with the Referee's conclusion that, because it was the employer's former claims processor, Continental was not a party to this proceeding. Although Continental was involved in the negotiations and was a party to the approved CDA, at the time of hearing, Continental was no longer retained as the employer's claims processing agent. Accordingly, the Referee correctly determined that Continental was not a "party," pursuant to ORS 656.005(20) and 656.283(1).

However, despite Continental's lack of standing as a "party" to this proceeding, it has a specific interest in the case as a result of its prior representation of the employer during the negotiations which led to approval of the CDA, as well as a general interest in the interpretation of ORS 656.236. Under such circumstances, we conclude that the brief submitted by Continental will be considered as an amicus curiae brief. See, e.g., Al S. Davis, 44 Van Natta 931 (1992); see also Jeffrey B. Trevitts, 46 Van Natta 1100 (Interim Order (1994).

Jurisdiction

The Referee concluded that the Hearings Division did not have jurisdiction over an issue involving a CDA. Relying on ORS 656.236(1), the Referee reasoned that CDA's are subject to Board approval. The Referee also determined, in accordance with ORS 656.236(2), that a Board order approving a CDA is not subject to review.

We hold that the Hearings Division has authority to resolve this dispute. In reaching this conclusion, we do not view this dispute as a challenge to the Board's order approving the CDA. Rather, we agree with claimant's characterization of this dispute as involving an interpretation of the CDA's provisions.

Claimant's challenge to Sedgwick James' refusal to pay temporary disability benefits represents a "matter concerning a claim," entitling claimant to request a hearing on this issue. See ORS 656.283(1). In Howard v. Liberty Northwest Ins., 94 Or App 283 (1988), the court held that the Hearings Division had jurisdiction to enforce a disputed claim settlement (DCS). The court found that the dispute directly involved a worker's right to receive compensation, and, because it did, it could be resolved only within the workers' compensation system. Howard v. Liberty Northwest Ins., supra.

In the present case, as in Howard, we find that this matter involves claimant's right to receive compensation. Here, Sedgwick James has declined to pay claimant temporary disability benefits on the ground that claimant released all of his rights to such benefits, including temporary disability, when he entered into the CDA. In essence, as in Howard, Sedgwick James is seeking "enforcement" of the CDA; i.e., an interpretation of the CDA in a manner that would not entitle claimant to further temporary disability benefits. Accordingly, because claimant's right to receive compensation is at issue, we conclude that this dispute must be resolved within the workers' compensation system, and claimant was entitled to request a hearing on the issue.

Claimant's request for hearing is, therefore, reinstated.

Compensability

In an alternative finding, the Referee concluded that, because claimant had entered into a CDA which released all benefits except medical services for the compensable injury, no further benefits were available to claimant under the 1989 claim. We agree.

On review, claimant relies on the CDA provision which states that "[t]he accepted conditions subject to claim disposition agreement are: lumbar sprain/strain and L4-5 disk protrusion." Yet, at the same time, claimant unqualifiedly released his right to "all other benefits except for medical services." (This provision is also consistent with the first page ("summary page") of the CDA which provides that the disposition was a "full release."). Finally, concerning what, if any, rights claimant was retaining, the agreement further provided that he "retains his right to medical services for the compensable injury." (Emphasis supplied).

The aforementioned provisions persuade us that claimant intended to release all rights to benefits (past, present, and future) due under his August 1989 injury claim. The reference in the CDA to a sprain / strain and the L4-5 disc as the "accepted conditions subject to this claim" was not complete, and, to that extent, it is inaccurate. We conclude that, had the parties intended to treat claimant's L5-S1 condition as outside the application of the full release, they would have used language in the CDA calculated specifically to convey the understanding that the CDA involved only a partial release of rights and benefits under the claim.

Not only is there no such exclusionary language in the CDA, the CDA contains other sections which indicate that no such exclusion was intended. First, the CDA lists the disposition as a "full release." Second, claimant's rights, and Continental's corresponding obligations to provide those rights are released for "all other benefits except for medical services." Third, and most importantly, the CDA includes an express provision addressing what rights claimant retains. That sentence expressly provides that "claimant retains his right to medical services for the compensable injury."

Thus, a review of the "four corners" of the CDA does not support claimant's interpretation that he retained continuing rights to "non-medical service" benefits for his L5-S1 condition or any other condition not specifically mentioned in the CDA. In other words, we do not consider the intentions of the parties as represented in the CDA to be ambiguous. Nevertheless, we acknowledge that the recitation of specific accepted conditions as subject to the CDA when considered with the inclusion of full release language and no specific "retention" provision other than for medical services could arguably raise a question concerning the intention of the parties.

To resolve the "ambiguity" and ascertain the parties' intent, we would consider the parties' communications around the time of the execution of the agreement.[1] A review of those communiques would conclusively confirm that the parties intended that claimant would retain only his right to medical services for his compensable injury. We would base this conclusion on the following reasoning.

On February 4, 1991, claimant's attorney at the time drafted a letter which confirmed claimant's settlement offer for "an immediate CDA (no more time loss, vocational assistance, permanent disability, etc.)." The letter did not indicate that claimant would retain any "non-medical service" benefit for any portion of his claim. On April 1, 1991, claimant's counsel forwarded the proposed CDA to the insurer for approval, noting that the insurer would continue to pay temporary disability pending Board approval of the CDA which would not be offset against the CDA proceeds. In return for such payments, claimant's counsel related that claimant's hearing request regarding the insurer's alleged improper calculation of his temporary disability rate was being dismissed.

Finally, according to the notice of rights which accompanied the CDA, claimant was advised that he was "release[ing] your right to: (1) Claim closure and disability rating (2) An award for permanent partial disability (3) Monthly payments for permanent total disability (4) Vocational assistance (5) Future time loss benefits. The only benefits you will not release is your right to medical benefits for the accepted condition." (Emphasis in original). The notice did not contain a statement that any "non-medical service" benefit for any portion of the claim would be retained.

Accordingly, since the CDA was executed and approved prior to any closure of the claim, the parties clearly understood that claimant not only released his rights to have his claim closed, but he also released any entitlement to permanent and total disability benefits resulting from claim closure. This conclusion is further supported by claimant's counsel's negotiation letter, as well as the notice of rights which accompanied the CDA. Neither document contained a statement that claimant retained any "non-medical service" benefit under his industrial injury claim. Therefore, we are convinced that the "full" release of "non-medical service" rights was just that, and the narrow construction claimant now has of the CDA is erroneous.

In concluding that, in this case, the parties' CDA disposed of claimant's claim, rather than merely one or two conditions, we note that ORS 656.236 provides that parties to a claim, "by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the director may prescribe." ORS 656.236(1)(Emphasis supplied).

The CDA itself repeated the release of those rights. Furthermore, the CDA identified the "claim" as having a September 15, 1989 date of injury. The CDA provided that the "claim" had not been closed and the "claim" was in accepted status. In other words, the parties' CDA in this case pertained to the "claim," as a whole.

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[1] Both claimant and Sedgwick James agree with the maxim that contracts are construed against the drafter of the document. Here, we agree with the Referee's finding that the CDA was drafted by claimant's prior counsel. (Exs. 19, 23). Consequently, any ambiguities must be resolved to claimant's detriment.

We find support for our conclusion in Krieger v. Future Logging, 116 Or App 537 (1992). In Krieger, the court held that the Board had correctly found that a CDA settled the claimant's aggravation claim. The court examined the language of the CDA which provided:

> "Pursuant to ORS 656.236, the parties have agreed to settle Claimant's claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except compensable medical services****. 'Compensation and payments of any kind due or claimed' includes temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and 'Own Motion' rights per ORS 656.278, but does not include compensable medical services."

In Krieger, the court found that the Board had correctly determined that the CDA resolved "any and all" claims arising from the claimant's compensable injury, including the claimant's aggravation claim. The court found that the claimant had released his rights by entering into the CDA, upon Board approval.

In the present case, the parties' CDA similarly provides that:

> "Pursuant to ORS 656.236, in consideration of the payment of $25,000 by the insurer, claimant releases his right to the following workers' compensation benefits: temporary disability, permanent disability, vocational rehabilitation and survivor's benefits, and all other benefits except for medical services. The insurer's obligation to provide these benefits is also released."

We construe this as a "full" release, having the same effect as the release in Krieger. This conclusion is further supported by the CDA provision in which claimant expressly retained "his right to medical services for the compensable injury." Under such circumstances, we hold that the CDA resolved "any and all" claims arising from claimant's compensable injury with the exception of medical services.

Claimant further argues that a Department rule, OAR 436-60-145(4)(a), requires that the parties specify the accepted condition or conditions that are the subject of the disposition. Claimant asserts that there would be no need for the Department's rule if the CDA disposed of all matters concerning the claim. We disagree.

In determining the reasonableness of an offer of settlement, it certainly would assist the parties to list the conditions that have been accepted.[2] Likewise, for determining whether the consideration for the release of benefits is "unreasonable as a matter of law," it would assist the Board to know what conditions were caused by the compensable injury. We believe that the Department rule serves these purposes. However, it does not necessarily follow that the failure of the parties to list all accepted conditions in the CDA will make a full release unenforceable, or indicate that a full release was not intended. Such a failure could have other consequences. For example, if it is brought to the Board's attention when the CDA is submitted for approval, the CDA may not receive Board approval. See e.g., Karen J. Vega, 43 Van Natta 176 (1991) (CDA disapproved for failure to list the accepted conditions). Here, however, such failure did not come to the Board's attention, and the CDA was finally approved.

Additionally, we have held that the ordinary function of a claim disposition agreement is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. Randi E. Morris, 43 Van Natta 2265 (1991); ORS 656.236(1). Without finding a specifically stated intention to do otherwise, we are unwilling to construe this CDA as disposing of only an accepted condition, as that condition existed at the time the Board received the CDA.

For the reasons previously expressed, we conclude that the present CDA does not merely dispose of the listed conditions. As noted above, the CDA summary page provides for a "full" release of benefits under the August 1989 injury claim. The CDA itself, drafted by claimant's counsel, does not provide that claimant releases his rights to the enumerated benefits for only the specified accepted condition. Rather, the CDA provides that claimant's rights to all benefits except for medical services have been released, in addition to releasing the insurer's obligation to provide those benefits. Moreover, the CDA expressly states that claimant retains his right to medical services for the compensable injury.

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[2] It would be reasonable to consider the present and potential future value of the claim.

Therefore, as previously stated, because claimant in this case released his rights to all benefits except medical services under the claim and expressly retained only his right to medical services for the compensable injury, he has disposed of his right to "non-medical service" benefits under the entire claim, including such benefits for the L5-S1 condition and all consequential or resultant conditions from the underlying claim. Thus, we consider it irrelevant to our analysis whether or not the L5-S1 condition was accepted at the time the CDA received Board approval. In light of this conclusion, we need not address claimant's contention that the L4-5 condition was the only specifically accepted condition. Likewise, it is similarly unnecessary for us to respond to the dissent's assertion that Continental did not accept the L5-S1 "condition" because of an allegedly defective acceptance by means of a "801" form.

Finally, by reaching this conclusion, we emphasize that our holding is not intended to suggest that parties may never dispose of only one condition (and its benefits) in a CDA if the parties so desire. We trust that a CDA drafted to obtain such a result would clearly declare the parties' intent to effect only a partial release of the claim, and a corresponding partial, rather than full release of the benefits arising under the claim. Additionally, if the parties wished to preserve a worker's entitlement to benefits arising from a consequential or resultant condition, we trust that the parties would also insert language clearly stating the parties' intentions. However, because the CDA in question contains no such language or reservations and in fact expresses an intention that only medical services benefits are retained, we conclude that the entire claim was settled pursuant to the CDA.[3]

Under the circumstances, we conclude that, by entering into this CDA, claimant fully released his rights to all benefits under the claim, not just benefits for the two listed conditions. Consequently, we hold that he is no longer entitled to receive temporary disability, permanent disability, vocational rehabilitation, or survivor benefits for that claim or for any resultant condition or component of the claim, including future, unidentified conditions which may someday arise from the claim. Such an interpretation is consistent not only with statutory and administrative requirements, but also with the express terms of the CDA. In other words, claimant fully released his right to all benefits under his August 1989 injury claim, with the exception of medical services.

Because claimant is now seeking benefits for a condition which he contends is related to his industrial injury and because claimant has previously released his "non-medical services" benefits for that claim pursuant to an approved CDA, we agree with the Referee that claimant cannot establish an entitlement to further temporary disability benefits. Furthermore, although claimant argues that he is entitled to have his claim closed by the employer, we note that, even if the claim is closed, claimant has released all rights to temporary and permanent disability benefits when he entered into the CDA.

Therefore, we affirm the Referee's alternative finding that claimant has not established an entitlement to "non-medical service" benefits for his L5-S1 condition.

ORDER

The Referee's order dated May 26, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which found that the Hearings Division was without jurisdiction is reversed. Claimant's request for hearing is reinstated. The remainder of the Referee's order is affirmed.

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[3] In the present case, the CDA provides only the required Departmental specification of the accepted conditions subject to the CDA on the first line of the CDA. The CDA does not later reiterate or single out the accepted conditions as the only conditions for which benefits are being released. Rather, the CDA, consistent with its summary sheet, specifically provides that all benefits, except medical services, are being released, "[P]ursuant to ORS 656.236 . . ."

Board Member Gunn specially concurring.

I agree with the majority's decision on the issues of standing and jurisdiction. I also agree with the majority that this claim disposition agreement (CDA) settled claimant's entire claim. However, I reach this conclusion for the following reasons.

First, I disagree with the majority's analysis regarding the summary sheet of the CDA, and its significance in this matter. The summary sheet is merely an administrative requirement to provide the parties and the Board with a brief recitation of the terms of the actual agreement. Therefore, I would not assign any special significance or meaning to the CDA summary sheet, and I would not rely on that portion of the CDA to resolve this dispute.

Furthermore, when taken as a whole, I consider the CDA to resolve a claim. A claim is composed of numerous elements, including rights to benefits, medical services, accepted conditions, and possible future or consequential conditions. Accordingly, a CDA must specify the particular benefits, rights, or future rights that a claimant is settling. Therefore, to be an effective settlement, and in order for a CDA to settle a claim, there must be a knowing waiver, by claimant, of his future rights and benefits. Furthermore, such a waiver must be clear and must be specifically provided for within the CDA.

In addition, I disagree with the majority's reasoning which provides that the parties must clearly set forth terms that provide for a partial release of benefits. The majority reasons that if such a partial release is not clearly defined by the CDA, then the document will be construed as a full release of benefits. I would hold to the contrary. If the parties' CDA contains no reference to a full release of benefits and future or consequential conditions, then I would construe the CDA as a partial release. In other words, such a CDA would only release benefits as to the specified condition, and would not release benefits that claimant may someday be entitled to for future conditions not released in the CDA. I find that, in an arena where most CDA's are drafted by carriers, such an approach would be consistent with the contract maxim of construing a document against the drafter.

Turning to the instant case, I would find that if the only accepted condition in the CDA was an L4-5 condition, then claimant would not have waived his right to future benefits for consequential or other conditions arising from the claim. In this case, however, the claim also included the accepted condition of strain/sprain. This accepted condition clearly encompasses the subsequent medical problem that led to claimant's need for medical services. Under the circumstances, a reading of the CDA's terms can only mean that: (1) the accepted conditions include the subsequent medical condition for which claimant now seeks compensation; or (2) an ambiguity is created as to the extent of the accepted conditions, sufficient to require inquiry into the parties' intent.

I conclude that, in this case, it is clear that the subsequent condition was part of the accepted strain/sprain, and therefore, was settled by the CDA. In the future, as in the past, I will interpret CDA's as contracts, and will look to the words of the contract to determine what was settled in a claim, absent any ambiguities. Consistent with such a position, where parties refer to specific, accepted conditions, and there is no clear waiver of future or consequential conditions, I will find that the parties have created a partial settlement of the claim, and will interpret the CDA as only settling the specified condition. Furthermore, I must emphasize that, in considering the effect of an approved CDA on a future claim for benefits, I will consider the most important factor to be whether benefits have been clearly and unambiguously waived in the CDA.

Because the present case does not involve such facts, however, I agree with the outcome of the majority's decision.

Board member Hall, concurring in part and dissenting in part.

Claimant sustained a low back injury on August 15, 1989 while working for the self-insured employer. Evidently, the employer completed an "801" form that indicated claimant had sustained a back "strain/sprain." (Ex. 1). On September 14, 1989, the employer's processing agent indicated on the "insurer use only" section of the "801" form that the agent had accepted a disabling injury claim. (Id.) No statutory notice of acceptance was ever issued.

On October 19, 1989, claimant was diagnosed with L4-5 disc and L5-S1 disc protrusions. (Ex. 6). The L4-5 disc protrusion was repaired on November 29, 1989. The employer paid claimant medical and non-medical benefits related to the L4-5 condition.

In January 1991, claimant's then-attorney began negotiating a claim disposition agreement (CDA) on claimant's behalf. (See Exs. 18-20). The parties executed the CDA in April 1991. It recited: "the accepted conditions subject to this Claim Disposition Agreement are: Lumbar sprain/strain and L4-5 disc protrusion." (Ex. 23-2). The CDA included a "full release" of temporary and permanent disability, vocational rehabilitation, survivor's benefits, and all other benefits, except medical services. (Id. at 1, 2-3).

In November 1991, claimant experienced increased back discomfort related to his L5-S1 disc herniation. That condition was surgically corrected on December 9, 1991. The employer paid for claimant's treatment for the L5-S1 condition.

In August 1992, claimant requested non-medical benefits (e.g., temporary disability) related to his L5-S1 condition. The employer's new processing agent denied the request, asserting claimant had released all such rights pursuant to the CDA. Claimant requested a hearing to contest the employer's refusal to provide non-medical benefits for the L5-S1 condition. The Referee held that he did not have jurisdiction to interpret the effect of the CDA on this claim. Alternatively, he held that the CDA precluded claimant from obtaining non-medical benefits for the L5-S1 disc protrusion.

Claimant requested Board review of the Referee's order, arguing that the Referee had jurisdiction to address this matter and that the CDA did not bar his claim for non-medical benefits relating to the L5-S1 disc protrusion. The majority of the Board has concluded that the Referee had jurisdiction to address this issue. I agree. My disagreement is with the majority's conclusion that, under amended ORS 656.236(1), the CDA operated to release claimant's rights with respect to the L5-S1 condition.

The majority believes that a CDA may "dispose of only one condition (and its benefits)", but that this particular CDA did not do so. (p. 19-20). The majority and the dissent are apparently in agreement that amended ORS 656.236(1) allows for the compromise and release of individual, medically-severable conditions that fall within the purview of a single claim. In other words, if an accepted claim consists of two or more conditions, the law allows a claimant to compromise and release one of the conditions while retaining rights and benefits for the others. This statutory interpretation is consistent with the analysis contained in this dissent, and supports the conclusions reached herein.

The majority also concludes, however, that claimant's L5-S1 condition was part of the claim that was subject to this CDA and "consider[s] it irrelevant to our analysis whether or not the L5-S1 condition was accepted at the time the CDA received Board approval." (p. 19). Because I believe that claimant's L5-S1 condition was not properly the subject of this CDA, I respectfully dissent.

To understand the statutory foundation for these conclusions, it is necessary to review the history of ORS 656.236 and the authority for claim disposition agreements.

Until 1990, ORS 656.236(1) provided that "[n]o release by a worker or beneficiary of any rights under ORS 656.001 to 656.794 is valid." That statute was construed as a strict prohibition against the release of any right once the worker or beneficiary acquired a right under Chapter 656. See EBI Companies v. Freschette, 71 Or App 526 (1984), rev den 298 Or 822 (1985) (disputed claim settlement that sought to extinguish the claimant's rights under original accepted claim held to violate former ORS 656.236(1); see also Walter E. Ginn, 36 Van Natta 1 (1984) (declining to approve stipulated agreement as being in violation of statutory prohibition against releases). The only qualifications to that general prohibition were ORS 656.289(4), which pertains to disputed claims settlements, and former ORS 656.587 (since amended by Or Laws 1990 (Special Session), ch 2, § 34), which governed settlement of third party complaints. See, e.g., Arnold Androes, 35 Van Natta 1619 (1983) (recognizing ORS 656.289(4) as exception to former ORS 656.236(1)); Roger Riepe, 37 Van Natta 3 (1985) (recognizing settlements under former ORS 656.587 as outside scope of former ORS 656.236(1)).

The unmistakable premise underlying former ORS 656.236(1) was the existence of an accepted claim (either by voluntary action of the employer-carrier or as a result of an order of the Hearings Division, Board or courts). See Freschette, supra (prohibition against release of rights attached to accepted, compensable claim). Once a claim was accepted, former ORS 656.236(1) would come into play, thus barring a worker's release of rights acquired under the claim (subject only to the two exceptions mentioned above).

In 1990, the legislature amended ORS 656.236 to provide, in part:

> "(1) The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the director may prescribe." Or Laws 1990 (Special Session), ch 2, § 9.

Hence, the "claim disposition agreement", or "CDA" came into existence.

A CDA functions to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. E.g., Donald Rhuman, 45 Van Natta 1493 (1993). The Director's rules define a CDA as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9) (emphasis added); see OAR 438-09-001(1) (defines CDAs as applying only to accepted claims); Lynda J. Thomas, 45 Van Natta 894, 895 (1993); see also OAR 436-60-145(4)(a) (requiring in CDAs the "[i]dentification of the accepted conditions that are subject of the disposition." (Emphasis added).). Indeed, because amended ORS 656.236(1) concerns the compromise and release of rights under a claim, it is axiomatic that the right to settle a claim pursuant to the CDA process does not vest until a claim is accepted.

The first issue in dispute is whether the employer accepted claimant's L5-S1 disc protrusion, thus rendering that condition amenable to compromise and release under amended ORS 656.236(1). Before analyzing that issue, I note that the parties assert the existence of certain commonalities between CDAs and disputed claim settlements (DCSs). ORS 656.289(4). A comparison of those two processes is therefore necessary.

CDAs and DCSs are both mechanisms for settling workers' compensation cases.[1] However, the similarity ends there. CDAs are designed to settle accepted claims, see OAR 438-009-001(1), whereas DCSs aim to settle denied or disputed claims where there exists a "bona fide" dispute regarding the compensability of a claim. See ORS 656.289(4); OAR 438-09-001(2); see also Freschette, supra (a "bona fide" dispute over compensability must exist before use of a DCS is allowed; there is no such dispute when a claim is already accepted as compensable). Accordingly, DCSs, but not CDAs, may be used to resolve claims processing disputes. See, e.g., Debbie K. Ziebert, 44 Van Natta 51 (1992); Debra L. Smith-Finucane, 43 Van Natta 2634 (1991). The two vehicles also differ in that CDAs may be approved only by the Board, amended ORS 656.236(1), whereas DCSs may be approved by a referee, the Board or the court. ORS 656.289(4). The dissimilarity between CDAs and DCSs is made clear by the fact that the Board requires that they be set forth in separate documents. OAR 438-09-010(7); 438-09-020(1)(b).

Under Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993), and Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), the court established that, if a stipulation contains language settling "all issues which were raised or raisable" at the time of settlement, the claimant will be barred from litigating conditions that were at issue at the time of settlement. DCSs often contain the "raised or raisable" boilerplate language, indicating that they intend to resolve all issues pertaining to a claim that were then raised or raisable. In contrast, because the "raised or raisable" language does not necessarily pertain to only an accepted claim, such language may not be included in a CDA under amended ORS 656.236 and the administrative rules. Victor F. Lambert, 42 Van Natta 2707 (1990); but see Krieger v. Future Logging, 116 Or App 537, 540 (1992), rev den 316 Or 528 (1993).[2] Even assuming, as an academic matter, that the "raised or raisable" language could properly be included in a CDA, that conclusion would have no bearing on this case, because the subject CDA did not include such language.

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[1] A third type of settlement vehicle is the settlement stipulation. This case does not involve such a stipulation and, thus, this dissent does not address that type of agreement.

[2] In Krieger v. Future Logging, supra, the issue relating to the CDA was whether a denied aggravation claim, related to an otherwise compensable, accepted claim, was subject to a CDA. The agreement contained language, "Additionally, all pending requests for hearing, if any, shall be dismissed with prejudice, as to all issues raised or raisable at this time." Id., 116 Or App at 540. Krieger did not address the propriety of using the "raised or raisable" language in a CDA.

The conclusion to be drawn from this comparison is that CDAs and DCSs are two very different vehicles for settling workers' compensation cases; vehicles with different purposes, different statutory underpinnings. Accordingly, I reject the parties' attempts to analogize this case, which concerns a CDA, to those involving DCSs.

To determine whether a claim may be subject to a CDA, it is necessary to distinguish between a claim and an accepted claim, for it is only the latter that may be compromised by a CDA. A "claim" is "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). The scope of a claim varies from case to case, at times being defined in terms of a claimant's symptoms or affected body part, and at other times being defined in terms of a specific condition or medical diagnosis. See, e.g., Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992) (physician's report requesting medical treatment for a specified condition constituted a claim).

In contrast, an accepted claim is a claim that a carrier has specifically and officially agreed is compensable and for which it has assumed responsibility. See ORS 656.262(6); Georgia-Pacific v. Piwowar, 305 Or 494, 500 (1988); compare Johnson v. Spectra Physics, 303 Or 49, 57 (1987) (in a partial denial, separate aspects of a single claim are treated as though they were separate claims).

Whether a claim has been accepted is a question of fact to be determined on a case-by-case basis. See SAIF v. Tull, 113 Or App 449, 454 (1992). In determining the limits of a "back-up" denial, the Supreme Court has held that, under ORS 656.262(6), acceptance of a claim encompasses only those conditions specifically and officially accepted in writing. Johnson v. Spectra Physics, supra, 303 Or at 55-56; see Bauman v. SAIF, 295 Or 788, 793-94 (1983). In the present case, the statutorily-required written notice of acceptance was never issued.

Merely paying or providing compensation is not considered acceptance of a claim or an admission of liability. ORS 656.262(9); e.g., Elmer L. Wille, 45 Van Natta 2040 (1993). Furthermore, a carrier's indication on the "insurer use only" portion of an "801" form (that it has accepted a claim) is not necessarily a valid written notice of acceptance if the carrier fails to send the marked claim form to the claimant. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 251 (1991); see also ORS 656.262(6).

Under the facts of this case, I would conclude that the employer did not accept claimant's L5-S1 disc protrusion. Claimant was injured on August 15, 1989. (Ex. 1). Thereafter, the employer evidently generated an "801" form that indicated that claimant had a back "strain/sprain." (Id.) On September 14, 1989, the employer's processing agent indicated on the "801" form that it had accepted claimant's back "strain/sprain" as a disabling injury. (Id.) Claimant was subsequently diagnosed with and treated for L4-5 and L5-S1 disc conditions. The employer paid for claimant's medical expenses related to both conditions (the latter, in December 1991, being the subject of debate here).

First, the employer's payment of claimant's medical expenses for the L5-S1 condition did not, by itself, constitute an acceptance. ORS 656.262(9); Elmer L. Wille, supra.

Second, contrary to the employer's assertion, the marked "801" form also did not constitute an acceptance of the L5-S1 condition (even if, arguably, it was a valid acceptance of a back "strain/sprain"). Although that form, as marked by the employer's processing agent, indicates that the employer had specifically accepted claimant's back "strain/sprain", the form fails to indicate whether claimant was officially notified of the acceptance by, for example, copying claimant with the form. Indeed, the employer appears to concede that it did not provide claimant with written (i.e., official) notice of its acceptance. (See Supplemental Response Brief of Hoffman-Marmolego & Sedgwick James at 4). Therefore, in the absence of evidence that claimant was apprised of the employer's "acceptance", I am compelled to conclude that the "801" form was not, by itself, a binding written notice of acceptance of any condition. See Stevenson v. Blue Cross of Oregon, supra; see also Johnson v. Spectra Physics, supra; Bauman v. SAIF, supra.

This raises an interesting issue. As mentioned earlier, this Board has held that CDAs may not be used as claims processing devices; rather, they are to be used only to dispose of accepted claims as those claims exist at the time the Board receives the CDA. E.g., Debbie K. Ziebert, supra; Debra L.

Smith-Finucane, supra; see ORS 656.236(1). Accordingly, CDAs may not be used to accept claims. Lynda J. Thomas, supra. Yet, that is precisely what appears to have happened here: The employer had not specifically and officially accepted any of claimant's conditions prior to the execution of the CDA. However, the CDA stated that only two conditions had been accepted; namely, lumbar strain/sprain and L4-5 disc protrusion. (Ex. 23-2). Therefore, it appears that the parties actually improperly used the CDA as a claims processing device. Be that as it may, because the CDA has become final by operation of law, that issue cannot be considered by us now. Therefore, we are bound to treat the two "accepted" conditions as just that: accepted. Because the CDA did not mention claimant's L5-S1 disc protrusion, however, this Board is not bound to conclude that that condition was accepted.

The employer argues that, under Georgia Pacific v. Piwowar, supra, its "801" form "acceptance" encompassed claimant's L5-S1 condition and, though not set forth in the body of the CDA, should be included in or subject to the CDA release. Even assuming that the "801" form constituted an acceptance of anything, the employer's argument under Piwowar fails.

Piwowar stands for the proposition that, where a carrier accepts a symptom of a disease, it also accepts the disease underlying the symptom. Id., 305 Or at 500. Here, the employer purportedly accepted claimant's back "strain/sprain." That is a disease (or condition), not a symptom. Moreover, even assuming that the back "strain/sprain" was a symptom, I have found no evidence that claimant's L5-S1 disc protrusion was a symptom of the back strain/sprain. See Dena G. Eldridge, 46 Van Natta 463, 464 (1994). Accordingly, even under Piwowar, I would conclude that the employer did not, by virtue of the "801" form, accept claimant's L5-S1 disc protrusion.[3]

Finally, relying on Safeway Stores, Inc. v. Seney, supra, the employer argues that claimant may not "recharacterize" his claim as having never been accepted to avoid the preclusive effect of the CDA. Seney is inapposite. It involved a stipulated settlement that purported to resolve all disputes regarding all issues "raised or raisable." The claimant had entered into a stipulation settling a denied aggravation claim, only to learn thereafter that the claim was a new injury claim. The court concluded that the claimant was bound by the stipulation because the compensability of claimant's condition, whether as an aggravation or a new injury, had been an issue during negotiations. Therefore, the court held that the claimant could not avoid his bargain by recharacterizing his claim after the fact. Id. at 454.

Here, we are dealing with a CDA, not a stipulated settlement regarding a denied claim. Furthermore, there is no "raised or raisable" language at issue in this case. Therefore, I find that Seney is of no assistance in analyzing this matter.[4]

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[3] The employer argues that, under Scott S. Hardy, 44 Van Natta 1749 (1992) and SAIF v. Abbott, 103 Or App 49 (1990), claimant's lumbar strain/sprain included claimant's L5-S1 condition. The employer states that, in Hardy, the employer accepted a lumbar strain condition that was held to include an L4-5 disc condition. It also states that, in Abbott, the claimant's wrist strain condition was held to include a later-diagnosed carpal tunnel syndrome.

The employer seriously misstates the facts of those cases. In Hardy, the carrier had accepted the claimant's condition, which had been diagnosed as lumbar strain with probable mild root irritation, while in Abbott, the carrier had accepted a wrist strain condition that had been described as involving swelling, aching and hand numbness. Because the acceptances in those cases included symptoms, this Board and the Court of Appeals held that, under Georgia-Pacific v. Piwowar, supra, the conditions causing those symptoms had likewise been accepted. Here, the "801" form on which the employer relies includes no symptoms. For that reason alone, I find the employer's reliance on Hardy and Abbott misplaced.

[4] In Debbie K. Ziebert, supra, this Board held that a CDA functions to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. The employer argues that, because claimant's L5-S1 condition was part of the claim when the CDA was received by the Board, the CDA disposed of claimant's rights with respect to the L5-S1 condition. That argument fails, because it neglects to take into account the fact that CDAs may only compromise accepted claims. Because claimant's L5-S1 condition was, at the time the Board received the CDA, not accepted, that condition could not have been compromised by the CDA. Again, a CDA is not a DCS containing the "raised or raisable" language, which arguably could include all conditions known to the parties when the agreement is negotiated.

Because the "801" form did not constitute an acceptance, for the employer to prevail there must be some other evidence of an acceptance of claimant's L5-S1 condition before or at the time of the CDA approval. I have found none.[5] I am compelled to conclude, then, that the employer never accepted claimant's L5-S1 disc protrusion. Therefore, because that condition was not accepted, it could not have been compromised or released by a CDA. E.g., Donald Rhuman, supra; Lynda J. Thomas, supra; OAR 436-60-005(9); OAR 436-09-001(1). Accordingly, I would hold that the CDA in no way bars claimant from seeking non-medical benefits for his L5-S1 disc protrusion in this proceeding.

Assuming arguendo that the employer had accepted claimant's L5-S1 condition, under a general contract law analysis, I would still conclude that claimant is not barred from claiming benefits for his L5-S1 disc protrusion, because that condition was not one of the accepted conditions specifically enumerated and thereby released under the terms of the CDA.

A CDA is a statutorily-authorized contract to which, the parties concede, general contract law applies. See, e.g., Fielda O. Durgan, 39 Van Natta 316, 318 (1987) (a workers' compensation settlement is a contract between the parties). The goal underlying the interpretation of a contract is ascertaining the parties' intent. In an unambiguous contract, that intent is plainly manifest. Therefore, unambiguous contracts are enforced according to their terms, without reference to any extrinsic evidence. See Timberline Equip. v. St. Paul Fire and Mar. Ins., 281 Or 639, 643 (1978). Whether a contract is ambiguous is a question of law. Id. Only when a contract is ambiguous do we resort to rules of construction and extrinsic evidence to ascertain the parties' intent. See id.; Good Samaritan Hospital v. Stoddard, supra, 126 Or App at 72.

The parties agree that the subject CDA is unambiguous. Claimant argues that the language from the CDA ("The accepted conditions subject to this Claim Disposition Agreement are: lumbar strain/sprain, and L4-5 disc protrusion[,]") clearly manifests the parties' intent to exclude the L5-S1 condition from the scope of the CDA. (Ex. 23-2). In contrast, the employer argues that the general release language in the CDA unequivocally reveals the parties' intent to compromise all issues regarding claimant's compensable injury. The general release language provides:

> "[C]laimant releases his right to the following worker's compensation benefits: temporary disability, permanent disability, vocational rehabilitation and survivor's rights, and all other benefits except for medical services. The insurer's obligation to provide these benefits is also released." (Id. at 2-3).

I find that this is an unambiguous contract. On its face, the CDA clearly states that it only applies to two conditions: lumbar sprain/strain and L4-5 disc protrusion. The employer's reliance on the general release language is misplaced, because that language concerns the type of benefits claimant released, and says nothing about the conditions that were the subject of the CDA. Therefore, because the CDA is unambiguous, its interpretation is a matter of law, based only on the four corners of the CDA itself.[6]

On the basis of my examination of the CDA, I would conclude that the parties did not intend to cover claimant's L5-S1 disc protrusion under this CDA. The CDA plainly states that it applies only to claimant's back strain/sprain and L4-5 disc protrusion. It says absolutely nothing about claimant's L5-S1 condition. On its face, that language reveals the parties' intent that claimant release his rights to benefits only to the former two conditions. For this reason, I would conclude that, even assuming that the employer had accepted claimant's L5-S1 condition, the failure to enumerate that condition in the CDA precludes the employer from raising the CDA as a defense to claimant's present L5-S1 disc protrusion claim.

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[5] Claimant argues that the fact that the CDA fails to identify the L5-S1 condition as one of the accepted conditions is evidence that that condition was not accepted. In this case, that argument has considerable appeal. See OAR 436-60-145(4)(a) (proposed CDA must identify accepted conditions that are the subject of the disposition).

[6] The employer argues that, pursuant to ORS 42.220, the Board is authorized to consider the circumstances surrounding the execution of the CDA to ascertain the parties' intent. The employer is wrong. ORS 42.220 governs the construction of instruments. Since one does not construe an unambiguous contract, which the employer agrees is at issue here, ORS 42.220 is inapplicable.

Assuming that the CDA was ambiguous, and that consideration of extrinsic evidence regarding the CDA was therefore proper, I would conclude that the other documents on which the majority and the employer rely (i.e., the CDA "Summary Sheet" and claimant's counsel's negotiation letters) are of no assistance to the inquiry. Those documents concern claimant's benefits, and not the specific conditions to which the CDA applied. Therefore, even taking into consideration the extrinsic evidence regarding this issue, I would reach the same conclusion set forth in the preceding paragraph, viz., that claimant's rights regarding his L5-S1 disc protrusion were not compromised by the CDA.

In conclusion, I would hold that, because claimant's L5-S1 disc protrusion was never accepted, claimant's rights with respect to that condition could not have been compromised by the CDA. Alternatively, assuming that the L5-S1 condition had been accepted, I would nevertheless conclude that, because the CDA failed to enumerate the L5-S1 condition as one of the accepted conditions that was being compromised by the CDA, and because I believe that amended ORS 656.236(1) authorizes claimants to settle fewer than all accepted conditions by way of a CDA, the current claim for non-medical benefits for that condition is not barred by the CDA.

For the foregoing reasons, I respectfully dissent.

In the Matter of the Compensation of
ALLEN B. WHITE, SR., Claimant
WCB Case No. 93-05625
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Podnar's order that set side its denial of claimant's cervical spine and left shoulder injury claim. In addition, the insurer challenges the attorney fee sought by claimant's counsel. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

On April 14, 1993, claimant sought treatment with Dr. Puziss. Dr. Puziss identified claimant's date of injury as "approximately 2/9/93."

Dr. Staver examined claimant on behalf of the insurer on April 23, 1993. Dr. Staver commented that claimant "is actually not sure of the date of that injury and states that he reported to his supervisor but a form was not filled out until later."

Leadman Tiedemann testified that claimant notified him immediately after the forklift accident. Tiedemann further testified that, although he normally records such events, he did not do so on this day and, now, cannot remember the date of the accident.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's work activities were a material contributing cause of his neck and shoulder disability and need for medical treatment. We agree, and adopt the Referee's reasoning and conclusion, with the following comments.

On review, the insurer first contends that "[a]t hearing, claimant changed his story and testified he did not know when he was really injured." Therefore, the insurer argues, claimant is not credible and "should have the burden to support his changed history with some evidence to corroborate his testimony."

The Referee did not make an express credibility finding. However, we infer that, overall, he found claimant credible because his findings of fact are based in large part on claimant's unrebutted testimony. Accordingly, we make the necessary credibility finding based on the substance of the witnesses' testimony, and not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

After our de novo review of the record, we do not find that claimant "changed his story" at the August 1993 hearing. To the contrary, claimant advised Dr. Puziss and Dr. Staver in April 1993 that he was "not sure" of the actual date of injury. Moreover, we are unaware how claimant could further "corroborate" the date of injury when Tiedemann, the superior to whom claimant promptly reported his work injury, failed to record the incident. In addition, claimant's testimony as to the approximate date of injury is unrebutted. For these reasons, we find claimant credible.

Concerning compensability, the insurer urges the Board to rely on the opinions of Dr. Puziss and Dr. Staver (over that of initial treating physician Miller) to find that the February 1993 injury could not be the material contributing cause of claimant's disability and need for treatment. Dr. Staver examined claimant one time. He opined only that the work injury was not the major contributing cause of claimant's condition and need for treatment. Dr. Staver never addressed the material contributing cause standard. Inasmuch as Dr. Staver's opinion does not address material causation, we afford his opinion little weight. See Somers v. SAIF, 77 Or App 259 (1986).

At his deposition, Dr. Puziss explained that it would be rare for symptoms to appear after several weeks, whereas waking with idiopathic neck pain is common. Therefore, Dr. Puziss opined that claimant's condition was more likely idiopathic. No matter how rarely a condition might occur in the general population, such a statistical improbability is insufficient to defeat a claim where medical evidence establishes that the condition did occur in a claimant's particular case. Stedman v. Garrett Freightlines, 67 Or App 129, 132 n.1 (1984) citing Lucke v. Compensation Dept., 254 Or 439 (1969). We find Dr. Puziss' opinion concerning this claimant to be not particularly persuasive. Accordingly, we decline to rely on his opinion.

On the other hand, we find Dr. Miller's opinion to be better explained. Consequently, as did the Referee, we defer to her opinion. Dr. Miller acknowledged that it is uncommon for acute symptoms to have such a delayed onset. Nevertheless, she persuasively explained that claimant, who has an extraordinary large muscular cervical structure and a high tolerance for pain, was unaware of the magnitude of his injury at the time. Further, Dr. Miller noted that claimant's process of recovery supported the resolution of a traumatic injury rather than a non-traumatic neck condition. Based on Dr. Miller's persuasive opinion, which considered causation in terms of claimant's particular physiology, we find that claimant has met his burden of proving a compensable cervical spine and left shoulder injury claim.

Finally, the insurer challenges the attorney fee sought by claimant's counsel on Board review. In light of the record, exhibits, and uncomplicated compensability issue, the insurer contends that the fee sought is excessive.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable carrier-paid attorney fee for claimant's counsel's services on review concerning the compensability issue is $1,200, to be paid by the insurer. In reaching this determination, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief and counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated February 17, 1994 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
AQEEL A. FURQAN, Claimant
WCB Case No. 93-09067
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Referee Emerson's order that: (1) set aside its denial of claimant's occupational disease claim for a stress-related mental disorder; and (2) awarded claimant's attorney an assessed fee of $10,000 for prevailing against its denial. In his brief, claimant seeks penalties and attorney fees for SAIF's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

We adopt and affirm the Referee's order with the following supplementation concerning penalties and attorney fees.

Attorney Fee at Hearing

The Referee awarded claimant's attorney an assessed fee of $10,000 for services at hearing. SAIF contends that the award is excessive. We disagree.

OAR 438-15-010(4) sets forth the following factors considered in determining a reasonable fee: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill and standing of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The hearing in this matter was conducted over two days and a total of fourteen witnesses testified. Claimant's attorney devoted 35 hours and 9 hours staff time in preparation for the hearing. Both attorneys are skilled and experienced in the area of workers' compensation law and the case was competently and strenuously litigated by both. This matter involves a mental stress claim. Due to the more stringent standard of proof in stress claims and their complicated nature, such claims are generally more difficult to prove than ordinary compensability cases. Because the claim was found compensable, claimant has an accepted claim and will receive medical treatment for his psychological condition. Claimant's attorney bore a significant risk that his efforts would go uncompensated in this mental stress claim.

Considering the above factors and applying them to this case, we find that the fee awarded by the Referee is reasonable.

Unreasonable Denial

In his brief, claimant contends that SAIF's denial is unreasonable and seeks penalties and attorney fees. In its reply brief, SAIF contends that the unreasonable denial issue was withdrawn at hearing. However, the hearing transcript indicates that claimant withdrew an issue of penalties for a discovery violation, but did not withdraw the issue of penalties and attorney fees for an unreasonable denial. (Tr. 2; 3). Accordingly, we address that issue.

A penalty may be assessed when an insurer "unreasonably delays or refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the insurer had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). "Unreasonableness" and "reasonable doubt" are to be considered in light of all the information available to the insurer at the time of denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, at the time it issued its July 26, 1993 denial, SAIF had a report from Dr. Parvaresh which indicated that claimant did not have a diagnosable psychiatric disorder. In order for a mental disorder to be compensable, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community. ORS 656.802(3)(c). Thus, on the basis of Dr. Parvaresh's July 17, 1993 report indicating that claimant did not have a psychiatric disorder, SAIF had a legitimate doubt as to its liability for the claim. Accordingly, penalties and attorney fees for an unreasonable denial are not warranted.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $2,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved. In determining a reasonable attorney fee for services on review, we have also considered SAIF's objection to claimant's statement of services. Finally, we have not considered claimant's counsel's efforts pertaining to the defense of the Referee's attorney fee award or the unreasonable denial issue.

ORDER

The Referee's order dated December 22, 1993 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by SAIF.

In the Matter of the Compensation of
MARYCAROL MOLIN, Claimant
WCB Case No. 93-02919
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Podnar's order that: (1) upheld both the self-insured employer's partial denial of claimant's current low back condition and its denial of her psychological condition; and (2) declined to assess an attorney fee for claimant's attorney's efforts before the Director regarding the issuance of a Director's order. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception, correction and supplementation. We do not adopt the Referee's last finding of fact.

Dr. Lakehomer, Ph.D., psychologist, did not examine claimant; instead, he performed a record review for the employer.

Following her 1975 L5-S1 fusion surgery for a preexisting spondylolisthesis condition, claimant was hospitalized multiple times for treatment of low back pain resulting from this preexisting condition and fusion. (Exs. 1, 3). Twice these hospitalizations were in psychiatric wards. In 1981, claimant was hospitalized for three weeks in the psychiatric ward at St. Vincent's Hospital. In January 1988, claimant was again hospitalized for about a week in the psychiatric ward at St. Vincent's Hospital. Claimant was diagnosed with and received treatment for hysterical conversion reaction. (Exs. 21, 22, 23, 24, 74-9, 74-10, 76, Tr. 31-32). Prior to the 1991 work injury, claimant received psychotherapy over a period of several years and was treated with antidepressant medication on occasion. (Ex. 74). Claimant has also suffered from an eating disorder in the past.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's reasoning and conclusions regarding the compensability of claimant's current low back condition and her psychological condition, with the following supplementation.

Current Low Back Condition

Dr. Thomas was claimant's treating orthopedist from February 1980 until about November 1991, which includes the periods of claimant's psychiatric hospitalizations. Based on his treatment history, Dr. Thomas opined that claimant's low back pain has a psychological component, which he considered important. (Exs. 66, 76).

In addition, Dr. Thomas' treatment period includes treatment before and after the July 27, 1991 work injury. Dr. Thomas opined that the work injury constituted a low back strain that was superimposed over the preexisting spondylolisthesis condition. (Tr. 39). Dr. Thomas noted that claimant was not seen for her low back condition between May 1988 and the time of the work injury in July 1991. However, Dr. Thomas explained that claimant had other extended periods of time in the past where she had not required treatment of her low back condition, notably between July 1983 and June 1986. (Tr. 33).

Based on his extensive treatment history with claimant, knowledge of claimant's symptoms before and after the work injury, and comparisons of medical tests before and after the work injury, Dr. Thomas opined that the work injury had not worsened claimant's preexisting condition and that her preexisting current spondylolisthesis and fusion were the major contributing cause of her current low back condition. (Exs. 56, 21, 22, 66, 76, Tr. 35-39).

Dr. Calhoun, claimant's current treating physician, opined that claimant's condition worsened following the work injury. (Ex. 64). Dr. Calhoun offers no explanation for this opinion.

Dr. Bedder, M.D., is treating claimant on referral from Dr. Calhoun in an effort to relieve claimant's pain with a spinal cord stimulator. Dr. Bedder opined that the work injury is the major contributing cause of the worsening of claimant's condition. (Ex. 81-2). However, Dr. Bedder also did not explain how claimant's condition had worsened other than to note that claimant had "maintained a fair level of functioning" until the work injury. Id.

On this record, we agree with the Referee that Dr. Thomas offers the most persuasive opinion and that claimant has failed to establish that the work injury is the major contributing cause of claimant's current disability and need for treatment.

Psychological Condition

At the time of the hearing, Dr. Olson, Ph.D., clinical psychologist, had treated claimant approximately a year. Dr. Olson initially performed a psychiatric examination of claimant in June 1992 to determine if she was an appropriate candidate for a spinal cord stimulator. (Ex. 51). At that time, Dr. Olson opined that claimant was "not exhibiting significant psychological and/or functional overlay associated with her current health status." (Ex. 51-4). On that basis, he opined that claimant was an appropriate candidate for a spinal cord stimulator. Id.

However, in October 1992, Dr. Olson opined that claimant had deteriorated psychologically, primarily due to her frustration in not obtaining funding for a trial of spinal cord stimulation. (Ex. 63). Dr. Olson diagnosed "Psychological Factors Affecting Physical Condition." Id. In responding to claimant's attorney's question as to whether the work-related back injury was the major contributing cause of this diagnosed psychiatric condition, Dr. Olson stated that claimant's "low-back condition and the stress in dealing with her chronic pain condition is the primary reason" for his diagnosis. (Ex. 63-2). Dr. Olson later stated that a strong case could be made that claimant's "injury, the course of rejection, not only by her employer but by her [private] insurance company, has certainly contributed and could be considered major contributing causes in the development of her psychological condition." (Ex. 80-4).

A "possibility" of a causal relationship is insufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981). However, even assuming that Dr. Olson's opinions as a whole go beyond the realm of a possible causal relationship to the work injury, given the fact that he discounts claimant's past psychiatric history without addressing it, we do not find his opinion persuasive.

Claimant's past psychiatric history includes two hospitalizations in a psychiatric unit, one in 1981 and one in 1988, with diagnosis of and treatment for hysterical conversion reaction. (Exs. 21, 22, 23, 24, 74-9, 74-10, 76, Tr. 31-32). In addition, at various times prior to the work injury, claimant received psychotherapy, including antidepressant medication at times. Claimant also suffered from an eating disorder prior to her work injury.

Dr. Olson focused solely on his clinical contact with claimant over the year he has treated her, without addressing her past psychiatric history. (Ex. 80). Instead, he criticizes "revisiting" claimant's past psychiatric history. (Ex. 80-2). Furthermore, he appears to characterize claimant's past psychiatric history as involving only an eating disorder, which he states is not a relevant clinical issue at this time. (Exs. 80-2, 80-5). It may be true that claimant's eating disorder is not a factor in her current

psychological condition; however, claimant's psychiatric history involved more than an eating disorder. Dr. Olson makes no reference to the other elements of claimant's psychiatric history.

Dr. Glass, examining psychiatrist, also diagnosed "Psychological Factors Affecting Physical Condition." (Ex. 74-15). Dr. Glass had a complete picture of claimant's psychiatric history. In well-reasoned opinions, Dr. Glass opined that the 1991 work injury was not the major contributing cause of claimant's psychological condition, but that this condition was longstanding and predated the 1991 work injury. (Exs. 74, 75, 77).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are persuasive reasons not to rely on the opinion of Dr. Olson. Although discounting claimant's past psychiatric history, Dr. Olson did not explain why that history did not affect her current psychological condition. In addition, Dr. Olson appeared to find that claimant's past psychiatric history included only an eating disorder, although it included several other factors.

Attorney Fees

Following an ORS 656.327 procedure, the Director issued an order finding a proposed trial of a spinal cord stimulator was appropriate medical treatment for claimant. The Director's order was not appealed and has become final as a matter of law. Subsequently, claimant requested a hearing on the compensability issues (addressed previously in this order) and also raised the issue of an assessed attorney fee for her attorney's services before the Director. Finding that the Hearings Division did not have jurisdiction over a request for attorney fees for services before the Director, the Referee declined to grant claimant's attorney's request. Although we find that the Hearings Division has jurisdiction over this attorney fee issue, we also find that claimant is not entitled to an attorney fee on the facts of this case.

The Director does not have statutory authority to award an attorney fee for counsel's services rendered in that forum. Any inequity that may result from this situation is a matter for the legislature, not the Board, to correct.

However, following an ORS 656.327 procedure before the Director which resulted in an order approving the medical treatment in question, claimant requested a hearing and raised, among other issues, the issue of attorney fees pursuant to ORS 656.386(1) for her counsel's services in obtaining compensation without a hearing. By seeking an attorney fee before the Hearings Division, claimant has submitted a claim for legal services. ORS 656.388(1); see, e.g., Beverly A. Kirk, 45 Van Natta 1193 (1993)(ORS 656.388(1) envisions a request for an attorney fee based on an attorney fee granted pursuant to a specific statutory authority). Because ORS 656.388(1) requires Board approval of a claim for legal services, we conclude that this grant of approval authority includes the authority to determine whether counsel is entitled to an attorney fee under ORS 656.386(1). Thus, we conclude that the Board and its Hearings Division have jurisdiction over the attorney fee issue.

Turning to the merits of this issue, claimant argues that the ORS 656.327 dispute constituted a denial of a claim for compensation. Furthermore, claimant argues, because she prevailed over that denial of compensation at the Director's review, she is entitled to an attorney fee pursuant to ORS 656.386(1). We disagree with claimant's underlying premise that a ORS 656.327 dispute is a denial of a claim for compensation.

There are three prerequisites for an attorney fee award under ORS 656.386(1). One, the claimant must initiate an appeal. Two, the appeal must be from an order or decision denying the claim for compensation. Three, the claimant must finally prevail on the issue of compensation. Shoulders v. SAIF, 300 Or 606, 611 (1986).

In Sherry Y. Drobney, 46 Van Natta 964 (1994), we determined that, inasmuch as a carrier is statutorily precluded from denying a medical services claim which is subject to the review procedures of ORS 656.327, the employer's refusal to pay for a surgery claim pending the review procedures of ORS 656.327 did not represent a decision denying a claim for compensation. ORS 656.327(1)(c).

On the other hand, in Drobney, we found that the Director's order finding the surgery inappropriate and the Referee's affirmation of that order represented orders denying a claim for compensation. Because the claimant had initiated review of the Director's and Referee's orders denying her claim for compensation and because she finally prevailed on Board review, we held that she was entitled to an attorney fee award under ORS 656.386(1).

Thus, when a carrier exercises its right to challenge a medical services claim by means of an ORS 656.327 resolution proceeding rather than by requesting a hearing under ORS 656.283(1), that initial action does not, by statute, constitute a decision denying a claim for compensation. Therefore, if a claimant prevails in that initial proceeding before the Director, ORS 656.386(1) has no application.

Here, the initial resolution proceeding was Director review under ORS 656.327. In accordance with the rationale expressed in Drobney, the employer's resort to that proceeding did not constitute a "decision denying a claim for compensation" as described in ORS 656.386(1). In addition, the Director's order found the medical treatment appropriate. Therefore, there has been no order denying a claim for compensation. Inasmuch as there has been no order or decision denying a claim for compensation, we hold that claimant is not entitled to a carrier-paid attorney fee award under ORS 656.386(1). Shoulders v. SAIF, supra.

ORDER

The Referee's order dated June 21, 1993 is affirmed.

September 6, 1994 Cite as 46 Van Natta 1785 (1994)

In the Matter of the Compensation of
MARK OSTERMILLER, Claimant
WCB Case No. 93-04010
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

The self-insured employer requests reconsideration of our July 21, 1994 Order on Review which reversed the Referee's order which had upheld the employer's denial of claimant's occupational disease claim for carpal tunnel syndrome. Specifically, the employer contends that we erroneously relied on the opinion offered by claimant's attending physician (rather than opinions from the physicians who examined claimant at the employer's request) and seeks reconsideration by the Board en banc.

On August 18, 1994, we withdrew our July 21, 1994 and August 15, 1994 orders for reconsideration. We now proceed with our reconsideration.

As a preliminary matter, we deny the employer's request for en banc review of this case. Although the Board may sit en banc in rendering a decision, the act or decision of any two members shall be deemed the act or decision of the Board. ORS 656.718(2). Whether a case is reviewed en banc is a matter that the Board decides on its own motion. After reviewing this case, the employer's request for en banc review is denied. See Ralph L. Witt, 45 Van Natta 449 (1993); Kurt D. Cutlip, 45 Van Natta 79 (1993); Brenda K. Allen, 45 Van Natta 2476 (1992).

In our original order, we relied on the opinion of claimant's attending physician, Dr. Roberts, after finding the opinions of the the employer's experts to be unpersuasive. We found that Drs. Button and Radecki based their opinions on a videotape that did not accurately reflect claimant's specific duties, that they had an inaccurate medical history, and that their conclusions regarding the cause of claimant's condition were based on statistical generalities rather than on claimant's own medical history and diagnoses.

The employer contends that we should disregard Dr. Roberts' opinion because he did not understand claimant's job duties, he was not aware of claimant's part-time status, he is not an expert in carpal tunnel syndrome, he did not notice the left hand discrepancy, and he was unaware of the extent of claimant's health problems.

After reviewing the employer's contentions, we continue to find, for the reasons expressed in our order, that Drs. Radecki and Button are not persuasive. Furthermore, we do not agree that Dr. Roberts did not understand claimant's job duties. A June 21, 1993 letter from Dr. Roberts to claimant's counsel explains Dr. Roberts' understanding of the length of time claimant had been working at his job, his job duties, and the hand position used to perform his work. Under such circumstances, we do not agree with the employer that Dr. Roberts had an incomplete or inaccurate description of claimant's work duties. Moreover, although Dr. Roberts may not specialize in carpal tunnel syndrome, he performed claimant's carpal tunnel release surgeries and reported both that claimant's diagnosis of carpal tunnel syndrome was not difficult to make and claimant had supporting electrical studies. Finally, we have found that Drs. Radecki and Button, who do specialize in carpal tunnel conditions, have not provided persuasive opinions in this case.

Next, the employer argues that Dr. Roberts was unaware of claimant's parttime status, his left-hand discrepancy, and the extent of his health problems. However, claimant's carpal tunnel condition arose prior to his "60 percent" status, which began in approximately August 1992, (Ex. 22), and lasted through March 1993. Furthermore, Dr. Roberts treated claimant during this time period and there is no indication that he was unaware of claimant's parttime status.

Dr. Roberts was also aware that claimant was left-handed and was aware of the electrical studies, which he found supported the carpal tunnel diagnosis. Although Dr. Radecki found the nerve conduction studies to be inconsistent with a theory of work causation, we have rejected Dr. Radecki's opinion for the reasons stated in our previous order.

Finally, the employer argues that Dr. Roberts was unaware of the extent of claimant's other health problems. Again, however, we disagree. The fact that Dr. Roberts did not agree with Drs. Button and and Radecki concerning a cardiac and edema diagnosis does not mean that he was unaware of claimant's status. To the contrary, Dr. Roberts reported that he had performed a heart and lung examination on claimant prior to surgery, and found no evidence of fluid accumulation in the lungs or a gallop in the heart suggestive of a cardiac problem.

Therefore, we continue to find that Dr. Roberts' opinion is more persuasive, both because it is well-reasoned and based on complete information and because we find no persuasive reasons not to defer to his opinion as the treating physician. Accordingly, we continue to adhere to our prior conclusion.

On reconsideration, we adhere to and republish our July 21, 1994 order in its entirety, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KERRY L. VANWAGENEN, Claimant
WCB Case Nos. 93-09510, 93-07350, 93-08302 & 93-09509
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

United Employers Insurance (United) requests review of that portion of Referee McCullough's order that: (1) set aside its denial of claimant's current bilateral carpal tunnel syndrome; and (2) upheld Bend Millwork Systems' (Bend Millwork's) denial of the same condition. Claimant cross-requests review of the Referee's order, asserting that she is entitled to an attorney fee award pursuant to ORS 656.307(5) or 656.386(1). On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt the Referee's conclusions regarding responsibility.

Attorney Fees

Claimant has cross-requested review of the Referee's order, asserting an entitlement to an attorney fee award pursuant to ORS 656.307(5) or 656.386(1). Both carriers contest claimant's entitlement to a fee under either statute.

Bend Millwork argues that, because claimant did not request an assessed attorney fee at hearing, she is estopped to request a fee on review. We disagree.

The doctrine of equitable estoppel is only intended to protect those who materially change their positions in reliance on another's acts or representations. Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992); Audrey L. Sanders, 46 Van Natta 1190 (1994). There is no evidence that Bend Millwork (or United, for that matter) materially changed its position in reliance on claimant's failure to specifically request an assessed attorney fee at hearing. Accordingly, we reject Bend Millwork's estoppel argument.[1] We turn to claimant's substantive arguments.

Claimant argues that, because a paying agent was designated before hearing and because responsibility was the only issue at hearing, she is entitled to an attorney fee under ORS 656.307(5). We disagree.

ORS 656.307(5) authorizes an attorney fee award, payable by the responsible carrier, in proceedings under that section if the claimant appears at any such proceeding and actively and meaningfully participates through an attorney. If a claimant does not advocate that a particular carrier is the responsible party, his or her participation is not "meaningful." Keenon v. Employers Overload, 114 Or App 344, 347 (1992). To be meaningful, the claimant must have a material, substantial interest in deciding who is the responsible party and must take a position advocating that interest. Id.

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[1] United argues that, because claimant did not request a separate attorney fee at hearing, she is precluded from doing so now. We understand the thrust of that argument to be that claimant has failed to preserve her right to request an assessed fee, and we disagree. See Frank P. Heaton, 44 Van Natta 2104 (1992) (attorney fee is natural derivative of compensability determination).

Claimant's amended requests for hearing identified attorney fees as one of the issues to be litigated; her August 26, 1993 amended request for hearing identified ORS 656.386(1) as the basis for the requested attorney fee award. At hearing, the Referee identified the issues as follows:

> "[T]here was a dispute about compensability between claimant and [Bend Millwork Systems], and claimant, as a result of that, has raised an additional issue in the claim involving Bend Millworks and Crawford [Bend Millwork's adjusting agent], and that is a claim of entitlement to a penalty of [sic] associated attorney fee based upon [Bend Millwork's] alleged unreasonable delay in accepting compensability." (Tr. 2).

Claimant's counsel agreed with that statement of the issues. (Id.)

On this record, we conclude that, in light of claimant's requests for hearing, which identified attorney fees (particularly pursuant to ORS 656.386(1)) as an issue, claimant adequately raised the issue of her entitlement to an attorney fee related to Bend Millwork's delay in conceding the compensability of her claim. Furthermore, we conclude that claimant's agreement with the Referee's statement of the issues, which included attorney fees related to the reasonableness of Bend Millwork's conduct, was not sufficient to manifest claimant's relinquishment of her claim for a statutorily-authorized attorney fee related to Bend Millwork's delay in conceding the compensability of her claim. See Liberty Northwest Ins. Corp. v. Alonso, 105 Or App 458, 460 (1991) (offset issue raised in employer's response to issues in request for hearing was properly before the Board notwithstanding that employer did not "raise" offset issue at hearing).

Here, claimant's counsel examined claimant at hearing. However, the record fails to show that claimant had a material, substantial interest in deciding who is the responsible party. Furthermore, even assuming that such an interest existed, there is no evidence that claimant took a position advocating that interest. On this record, we find that claimant did not actively and meaningfully participate through an attorney in this proceeding. Keenon, supra. Accordingly, we conclude that she is not entitled to an attorney fee pursuant to ORS 656.307(5).[2]

We turn to claimant's assertion that she is entitled to an attorney fee under ORS 656.386(1). That statute authorizes an award of attorney fees if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held[.]"

Here, claimant filed a claim for bilateral carpal tunnel syndrome with Bend Millwork and United's insured. Bend Millwork initially denied both compensability of and responsibility for the claim. (Ex. 13). Claimant's counsel filed a request for hearing, listing compensability as one of the issues. Bend Millwork subsequently amended its denial to disclaim responsibility only. (Ex. 20). We conclude that, on this record, counsel's request for hearing was sufficiently instrumental to serve as the basis of an attorney fee award pursuant to ORS 656.386(1). See David K. Krueger, 45 Van Natta 1131 (1993) (request for hearing preserved claimant's right to challenge the employer's denial and was sufficient to warrant an assessed fee under ORS 656.386(1)); see also Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (claimant's counsel entitled to carrier-paid fee under ORS 656.386(1) when carrier rescinded compensability portion of denial before hearing regarding responsibility for claim).[3]

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's pre-hearing services concerning the rescission of Bend Millwork's compensability denial is $500, to be paid by Bend Millwork. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated January 12, 1994 is affirmed in part and modified in part. For pre-hearing services regarding the compensability issue, claimant's counsel is awarded $500, to be paid by Bend Millwork Systems. The remainder of the Referee's order is affirmed.

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[2] On review, claimant first mentioned ORS 656.307 in the course of arguing that she was entitled to an attorney fee under ORS 656.307(5). It is unclear whether this matter was a proceeding under ORS 656.307. We need not resolve that issue, however, since we have concluded that, for the reasons stated above, claimant is not entitled to an attorney fee pursuant to ORS 656.307(5).

[3] Bend Millwork argues that, under SAIF v. Allen, 124 Or App 183 (1993), rev allowed 318 Or 478 (1994), claimant is not entitled to an attorney fee pursuant to ORS 656.386(1), because compensability of her condition was no longer at issue. We disagree. Bend Millwork's argument ignores our order in Penny L. Hamrick, supra. Furthermore, in Gwen A. Jackson, 46 Van Natta 822 (1994) (order on reconsideration), we examined the Allen court's plurality opinion and concluded that the critical inquiry under ORS 656.386(1) was whether the carrier's conduct constituted a decision denying the claimant's claim for compensation. Bend Millwork does not dispute that its initial denial constituted a decision denying claimant's claim for compensation.

In the Matter of the Compensation of
JACQUELYN E. BAILEY, Claimant
WCB Case No. 93-04303
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes, Westerband, and Hall.

Claimant requests review of Referee Podnar's order that dismissed claimant's hearing request seeking an attorney fee under ORS 656.386(1) for her counsel's efforts regarding a Director's order which found that claimant was entitled to choose her attending physician. On review, the issues are jurisdiction and attorney fees. We reinstate claimant's hearing request, but decline to award an assessed attorney fee.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on September 18, 1989. On December 21, 1990, the insurer informed claimant that, pursuant to OAR 436-10-060, she had exhausted her three choices of an attending physician, and since it had not approved Dr. Long as her fourth attending physician, it had not paid Dr. Long's medical bills.

Claimant requested Director review to approve Dr. Long as her attending physician. The Medical Review & Abuse Section (MRAS) of the Workers' Compensation Division issued an order concluding that claimant had not exceeded her statutory right to select an attending physician; and, therefore, claimant could select Dr. Long as her attending physician without the Director's approval. The insurer then requested a hearing before the Director. The Director affirmed the order of the MRAS and ordered that the insurer could not refuse to pay Dr. Long's bills on the ground that claimant had exceeded her statutory right to select an attending physician under ORS 656.245(3). Based on the Director's order, the insurer paid Dr. Long's medical bills. Neither party appealed the Director's order, and thus, it has become final by operation of law.

Claimant then requested a hearing seeking an attorney fee under ORS 656.386(1) for her counsel's services before the Director.[1] No issues relative to claimant's entitlement to compensation were raised at hearing. The Referee determined that neither the Hearings Division nor the Board had jurisdiction to determine whether claimant should obtain compensation. The Referee, therefore, concluded that the Hearings Division lacked jurisdiction to award an attorney fee for efforts in another forum. Accordingly, the Referee dismissed claimant's request for hearing.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, claimant has submitted a supplemental memorandum of authorities. The insurer objects to this submission. The parties may submit supplemental authorities advising of recent changes in the law that are relevant to the decision. We will consider all arguments to the extent they provide supplemental authority. Debra A. West, 43 Van Natta 2299 (1991); Betty L. Juneau, 38 Van Natta 553 (1986).

We agree with the Referee that the matter before the Director did not concern a claim under ORS 656.704(3). The parties did not dispute the causal relationship between Dr. Long's treatment and claimant's compensable condition. Rather, the insurer refused payment on the ground that Dr. Long was not an approved attending physician. Claimant then invoked the Director's authority to resolve the matter. See ORS 656.245(3)(a).

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[1] Claimant concedes that she could not seek an assessed attorney fee for her counsel's services from the Director because there is no statutory authority for an attorney fee for those services. Any inequity that may result from this situation is a matter for the legislature, not the Board, to correct.

ORS 656.245(3)(a) requires Director approval of claimant's selection of another attending physician. Without that approval, claimant may not change from her third attending physician. Like ORS 656.245(1)(b), there is no alternative procedure under ORS 656.245(3)(a) to review the insurer's decision not to approve subsequent changes in attending physicians. Also like ORS 656.245(1), ORS 656.245(3) provides a "proceeding for resolving a dispute regarding medical treatment" within the meaning of ORS 656.704(3). Tracy Johnson, 43 Van Natta 2546 (1991). Therefore, the medical services dispute was within the exclusive jurisdiction of the Director. ORS 656.245(3)(a); Hathaway v. Health Future Enterprises, 125 Or App 549 (1993); Tracy Johnson, supra.

Review of the Director's order was to the Court of Appeals. ORS 183.482; OAR 436-10-060(7). Thus, even if the Director's order was not final, neither the Hearings Division nor the Board had the authority to review the Director's order. Here, however, we are not reviewing the Director's order. The question is whether the claimant's attorney is entitled to an attorney fee under ORS 656.386(1). We conclude that we have jurisdiction to determine that question.

The Director did not have statutory authority to award an attorney fee for counsel's services rendered in that forum. Claimant, thus, requested a hearing seeking an attorney fee under ORS 656.386(1), for her counsel's services in obtaining compensation without a hearing.[2] By seeking an attorney fee before the Hearings Division, claimant has submitted a claim for legal services. ORS 656.388(1); see, e.g., Beverly A. Kirk, 45 Van Natta 1193 (1993) (ORS 656.388(1) envisions a request for an attorney fee based on an attorney fee granted pursuant to a specific statutory authority). Because ORS 656.388(1) requires us to approve such a claim, we conclude that this grant of approval includes the authority to determine whether counsel is entitled to an attorney fee under ORS 656.386(1). Accordingly, we have jurisdiction over claimant's request for hearing.

There are three prerequisites to the applicability of the attorney fee provision of ORS 656.386(1):

> "(1) the claimant must initiate the hearing process by requesting review from an order or decision denying the claim;
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> "(2) the claimant must prevail finally on the issue of compensation (before the forum in which the claimant is the initiating party); and
>
> "(3) the decision of the referee, board or court in which the claimant prevails finally must be from an earlier decision or order denying, rather than allowing, the claim for compensation." Shoulders v. SAIF, 300 Or 606 (1986).

In Sherry Y. Drobney, 46 Van Natta 964 (1994), we identified the critical inquiry, for determining claimant's entitlement to an attorney fee under ORS 656.386(1), as whether the carrier's conduct in refusing a medical services claim constituted a decision denying the claimant's claim. See also Gwen A. Jackson, 46 Van Natta 822 (1994). In Drobney, we found that the employer's refusal to pay the claimant's surgery claim was not a denial of compensation since ORS 656.327 precluded the employer from denying a medical services claim. We found, however, that the Director's order declaring the medical treatment not compensable and the referee's order affirming the Director's order constituted orders denying claimant's claim for compensation. Since claimant had satisfied the prerequisites by finally prevailing over those decisions on Board review, we held that she was entitled to an ORS 656.386(1) attorney fee.

Here, the insurer neither contested the causal relationship between claimant's medical services claim and her compensable condition, nor contended that the treatment was inappropriate. Rather, the insurer notified claimant that it was requiring her to seek Director approval of her proposed change of attending physician. Inasmuch as this is an action consistent with the insurer's statutory authority under ORS 656.245(3), we do not consider such an action (and the insurer's accompanying challenge to Dr. Long's bill) to constitute a "decision denying a claim for compensation" as described in ORS 656.386(1).

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[2] In finding that we have jurisdiction, we reject claimant's contentions that ORS 656.386, itself, grants the Hearings Division jurisdiction to award an assessed attorney fee and that the statute does not limit assessed attorney fees to proceedings before the Hearings Division or the Board.

We rejected a similar bifurcation argument in Gloria I. Shelton, 44 Van Natta 2232 (1992). In Shelton, we stated that ORS 656.386(1) must be read in its entirety. In doing so, we found that the amendment to the statute did not create a new class of assessed attorney fee where compensation was obtained and a hearing before the referee was not held. Id. at 2232-2233.

In addition, the Director's order allowed, rather than denied, Dr. Long as claimant's treating physician. Consequently, we conclude that there has been no order denying a claim for compensation. Inasmuch as there has been no order or decision denying a claim for compensation, we hold that claimant is not entitled to a carrier-paid attorney fee award under ORS 656.386(1).

ORDER

The Referee's order dated July 22, 1993 is reversed. Claimant's hearing request is reinstated. Claimant's request for an attorney fee is denied.

Board Member Westerband specially concurring.

I agree with the lead opinion's conclusion that ORS 656.386 does not authorize this Board to award claimant's counsel a fee for his services in a case within the exclusive jurisdiction of the Director. I write separately to emphasize one point.

The services rendered were provided in a case within the exclusive jurisdiction of the Director, subject to the parties' right of appeal directly to the Court of Appeals. I don't believe that ORS 656.386 applies under these circumstances. In my opinion, the necessary predicate for the statute's application is that the claimant could request a hearing with the Board for review of a denial. In that circumstance, the Board may award a fee, either if the claimant prevails at hearing, or obtains compensation without a hearing. Here, the necessary predicate is absent. The question was a matter within the province of the Director.[1] It was not a Board matter about which the Board could award a fee or any other relief.

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[1] The dissent contends that claimant essentially satisfied the statutory prerequisite of ORS 656.386(1) by requesting a hearing seeking an attorney fee for being instrumental in obtaining compensation for claimant without a hearing. Had claimant's attorney filed a hearing request contesting a "de facto" denial concerning the insurer's failure to timely respond to an unpaid medical bill and had the insurer paid that bill prior to hearing, I might be inclined to agree. However, that scenario was not presented in this case.

The insurer did pay the medical bill following the issuance of the Director's "245" order. Nevertheless, claimant's attorney testified that all services for which a fee was being requested were devoted to the Director's "245" proceeding. In other words, the basis for claimant's attorney fee award was not services regarding a "de facto" denial from an unpaid medical bill. Rather, claimant's theory was her counsel was entitled to a "386(1)" attorney fee for services solely devoted to the Director's "245" proceeding. Inasmuch as the Board lacks appellate review authority over a Director's "245" order, it likewise follows that services expended before such Director proceedings do not constitute grounds on which to base an attorney fee award under ORS 656.386(1).

Board Member Hall dissenting.

The majority has correctly concluded that the issue of claimant's entitlement to an attorney fee is within the Board's jurisdiction. I disagree, however, with the majority's conclusion that claimant is not entitled to an attorney fee under ORS 656.386(1). I, therefore, respectfully dissent.

Before proceeding with a discussion of attorney fees, I offer the following in response to the special concurrence. The Director had exclusive jurisdiction over the issue of changing physicians. The Director did not have jurisdiction over the insurer's failure to pay medical benefits pending Director review. The carrier should have paid for the medical services rendered up to the date of the carrier's notice informing claimant that further payments would not be made. OAR 436-10-060(4). Claimant's entitlement to a fee is for successfully obtaining payment of denied compensation. In other words, claimant technically did as the special concurrence suggests: request a hearing seeking a fee for obtaining compensation without a hearing. (See Tr. 1).

The prerequisites for obtaining a fee under ORS 656.386(1) are:

"(1) the claimant must initiate the hearing process by requesting review from an order or decision denying the claim;

"(2) the claimant must prevail finally on the issue of compensation (before the forum in which the claimant is the initiating party); and

> "(3) the decision of the referee, board or court in which the claimant prevails finally must be from an earlier decision or order denying, rather than allowing, the claim for compensation." Shoulders v. SAIF, 300 Or 606 (1986).

In order to determine the applicability of ORS 656.386(1) to the instant case, it is first necessary to examine the facts of this case and to then examine ORS 656.245(3), under which this case arose, and its significantly different -- though often confused as similar -- companion, ORS 656.327. Indeed, it is the difference between these two statutory provisions which allows claimant to obtain a fee under the facts in the present case.

In 1990, claimant sought the services of Dr. Eric Long for treatment of her compensable condition. Treatment was rendered and medical expenses were incurred. On December 21, 1990, the carrier informed claimant that, in the carrier's view, she had "exhausted" her three choices of attending physicians. The written notice also included:

> ". . . As we have not given any approval for a change in attending physicians, so as to advise you that we will not cover the cost of any medical bills from any other doctor.
>
> * * * * *
>
> "If you feel that additional medical treatment is necessary as a result of your injury, I would highly recommend that these bills be referred to your private carrier as they are noncompensable under the rules for Workers' Compensation." (Ex. 1).

Thereafter, claimant's counsel initiated the statutory review process provided in ORS 656.245(3). Claimant's appeal resulted in a favorable administrative "ORDER" issued by the Assistant Manager of the Workers' Compensation Division's Medical Review and Abuse Section of what was then called the Department of Insurance and Finance. (Ex. 8). The carrier then appealed the Assistant Manager's order. The history of this case, including the issues and arguments presented by the parties, is well summarized in the Director's "FINAL ORDER." (Ex. 21) In its appeal, the carrier argued that the Assistant Manager's order (i.e., the initial order of the Department of Insurance and Finance) was not valid (void ab initio). Rejecting the carrier's position, the Director held:

> "The authority to approve additional changes of attending physician beyond the statutory limit of three must encompass the authority to decide whether the claimant has, in fact, exhausted those three choices. Once the Division had correctly determined that claimant had 'not exceeded her statutory right to select an attending physician,' it was well within the Division's authority under ORS 656.245 and OAR 436-10-060 to conclude that the insurer could not require Director approval of Dr. Long. Claimant is free to choose a third attending physician. The insurer cannot refuse to pay the physician's bills on the theory that the worker has exceeded her three statutory choices." (Ex. 21-5, -6).

The employer/carrier stipulated that the subject medical bills were not paid until August 26, 1992, and were paid as a result of the Director's Final Order (Tr. 2, 3).

In Sherry Y. Drobney, 46 Van Natta 964 (1994), this Board analyzed applicability of ORS 656.386(1) in a case of the Director's review of a medical dispute under ORS 656.327. It is significant to note that ORS 656.327(1)(c) specifically states:

> "The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section." ORS 656.327(1)(c). (Emphasis added).

That statutory prohibition against actually denying medical services was critical to the Board's analysis and ultimate decision in Drobney.

ORS 656.245 (the subject of the present case) does not contain any such stay of a denial. Therefore, it can not be said, as a matter of law, that no denial of medical benefits (compensation) occurred in the present case before the initial favorable order. This statutory difference distinguishes ORS 656.327 from ORS 656.245 and Drobney from the instant case. Here, we must make the factual determination: were benefits denied and, if so, did claimant initiate an appeal process which resulted in a favorable order? Shoulders, supra.

In the present case, the carrier specifically issued a denial of medical benefits. (Ex. 1). As a result of claimant's appeal of that denial, claimant received a favorable order (Ex. 8), which was upheld on further review, resulting in the change of physician and the payment of medical bills. All three criteria for an award of attorney fees under ORS 656.386(1) have been satisfied. Shoulders, supra. While claimant is not entitled to a fee under ORS 656.386 for obtaining an initial favorable decision from the Director's under ORS 656.327 (Drobney, supra), claimant is entitled, in this case, to a fee under ORS 656.386(1) for a favorable order under ORS 656.245.

In the Matter of the Compensation of
CRAIG A. HINERMAN, Claimant
WCB Case No. C4-01253
ORDER OF ABATEMENT
Charles G. Duncan, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On May 18, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

On June 20, 1994, we approved the proposed agreement. Recently, it came to our attention that the parties had submitted an addendum to the CDA on June 17, 1994, prior to the time of approval of the CDA. Apparently, that addendum was misrouted within the agency and did not come to the attention of the Board before the CDA was approved. Consequently, because the addendum was timely filed by the parties, we treat the addendum as a request for reconsideration. See OAR 438-09-035.

Here, the addendum states in part:

> "The $11,625.00 payable to claimant after attorney fees and costs in this case are therefore prorated over his remaining life expectancy at the rate of $23.06 per month." (Emphasis added).

We have previously disapproved a CDA containing a reference to costs, which the Board has held is not a matter for disposition under ORS 656.236. See Robert G. Vandolah, 45 Van Natta 2109 (1993); Debbie K. Ziebert, 44 Van Natta 51 (1992).

In Vandolah, supra, claimant contended that the reference to attorney's costs in the CDA was necessary for the purpose of Social Security benefits. Notwithstanding the claimant's concerns regarding a possible Social Security offset, we held that a CDA containing such a cost reference could not be approved. Here, the reference to "costs" appears to be placed in the CDA for the same reason as expressed in Vandolah.

Therefore, in order to further consider the parties' timely filed motion for reconsideration (and thereby to consider their amended CDA), we withdraw our June 20, 1994 approval of the CDA. The parties are granted an opportunity to respond. To be considered, the parties' respective responses shall be due within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA L. ROW, Claimant
WCB Case No. 93-12315
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Hall.

The SAIF Corporation requests review of Referee Livesley's order which: (1) awarded claimant an assessed attorney fee under ORS 656.386(1) for her counsel's efforts in obtaining the rescission of a "de facto" denial of her claim for patellar subluxation; and (2) awarded claimant an assessed attorney fee under ORS 656.382(1) for allegedly unreasonable resistance to the payment of compensation. On review, the issues are attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his "finding of ultimate fact" that SAIF's "de facto" denial constituted unreasonable resistance to the payment of compensation.

CONCLUSION OF LAW AND OPINION

SAIF contends that the Referee erred in awarding an assessed attorney fee under ORS 656.386(1) for its "de facto" denial of claimant's patellar subluxation condition. It cites our decision in Cheryl L. Herring, 46 Van Natta 923 (1994). In Herring, we declined to award an attorney fee under ORS 656.386(1) when we agreed with the Referee's factual determination that there had not been a "de facto" denial.

We find the present case to be distinguishable. Here, we agree with the Referee's factual determination that SAIF had denied "de facto" claimant's patellar subluxation condition. SAIF had notice of a patellar injury prior to accepting claimant's left knee strain on May 21, 1993. More than 90 days passed before SAIF issued an amended notice of acceptance of the patellar condition on November 29, 1993, after a hearing request had been filed. Accordingly, we conclude that the condition had been "de facto" denied prior to its acceptance, and we affirm the Referee's award of assessed attorney fee under ORS 656.386(1). See Barbara J. Fuller, 46 Van Natta 1129 (1994); Wesley R. Craddock, 46 Van Natta 713 (1994).

SAIF also contends that, if claimant is entitled to an assessed attorney fee under ORS 656.386(1), the Referee's award of $1,850 was excessive. We agree.

In evaluating SAIF's contention, we consider the factors recited in OAR 438-15-010(4), noting that the value to claimant of the interest involved and the benefit secured for the represented party are but two of those factors. Accordingly, we also consider: (1) the time devoted to the case; (2) the complexity of the issue involved; (3) the skill of the attorneys; (4) the nature of the proceedings; (5) the risk in a particular case that an attorney's efforts may go uncompensated; and (6) the assertion of frivolous issues or defenses. Having considered these factors and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services concerning the "de facto" denial issue is $750. In reaching this conclusion, we have particularly considered the value of the interest involved, the complexity of the issue and the time devoted to the issue (as represented by the record). We modify the Referee's award accordingly.

SAIF also asserts that the Referee erred in awarding an assessed attorney fee under ORS 656.382(1) for unreasonable resistance to the payment of compensation. We agree.

In this case, there is no question that SAIF paid all compensation due concerning claimant's patellar subluxation condition. The Referee, nevertheless, awarded an assessed attorney fee because he concluded that SAIF's failure to accept the patellar subluxation condition was resistance to paying any possible permanent disability for that condition. We disagree with the Referee's rationale.

In SAIF v. Condon, 119 Or App 194 (1993), SAIF did not accept the claimant's injury-related psychological condition within 90 days of notification of treatment, although SAIF had paid all medical bills for claimant's psychological treatment. The court reversed our award of attorney fees under ORS 656.382(1), finding that there could be no unreasonable resistance to the payment of compensation when all compensation had been paid. 119 Or App at 196.

Likewise, in this case, all compensation for claimant's patellar subluxation had been paid. In this regard, we disagree that SAIF's conduct represents an unreasonable resistance to the payment of "possible" future permanent disability. To begin, permanent disability, if any, would only become due upon claim closure once claimant's condition became medically stationary. Moreover, the same rationale could have been used to justify an award of attorney fees in Condon, yet an award of attorney fees under ORS 656.382(1) was not made based on the possibility of a future permanent disability award for claimant's psychological condition. See also Cheryl L. Herring, supra (claimant was not entitled to attorney fee under ORS 656.382(1) when all compensation for a cervical condition allegedly denied "de facto" had been paid); Ozetta L. Domitrovich, 37 Van Natta 1553, 1555 (1987).

In conclusion, based on Condon and Cheryl L. Herring, supra, we disagree with the Referee's assessment of an attorney fee pursuant to ORS 656.382(1). Thus, we reverse that portion of the Referee's order.

Finally, claimant contends that she is entitled to an attorney fee, plus statutory interest, for her counsel's efforts on review concerning the attorney fee issue. Claimant asserts that the amendments to ORS 656.313 since Dotson v. Bohemia, 80 Or App 233 (1986), have demonstrated an intention to include attorney fees within the definition of "compensation."

Even assuming that attorney fees are "compensation," we have reduced the amount of claimant's attorney fee award on review. Thus, claimant's counsel would not be entitled to an award for services on review, even if we were to accept claimant's argument. See ORS 656.382(2).

Moreover, we find no indication in ORS 656.313 that the legislature intended to broaden the definition of "compensation" so as to overrule Dotson, supra. While an out-of-compensation attorney fee is "compensation," see Steiner v. E. J. Bartells Co., 114 Or App 22 (1992), the attorney fee in this case is a carrier-paid fee. Absent a clear indication that Dotson is no longer valid precedent, we continue to hold that an attorney fee is not available for defending a referee's attorney fee award because the latter is not "compensation." It, therefore, follows that statutory interest, which is based on "compensation," is also not available to claimant. See Markus M. Tipler, 45 Van Natta 216 (1993).

ORDER

The Referee's order dated February 15, 1994 is affirmed in part, modified in part and reversed in part. In lieu of the Referee's $1,850 attorney fee award for obtaining the rescission of the SAIF Corporation's "de facto" denial, claimant's counsel is awarded an assessed attorney fee of $750, payable by SAIF. The Referee's award of an assessed attorney fee for SAIF's allegedly unreasonable resistance to the payment of compensation is reversed. The remainder of the Referee's order is affirmed.

Board Member Hall dissenting in part.

Although I agree with the majority that claimant's counsel is entitled to an assessed attorney fee under ORS 656.386(1) for his efforts in obtaining rescission of SAIF's "de facto" denial, I part company with the majority with respect to its reduction of claimant's attorney-fee award under that statute. I also disagree with the elimination of the Referee's attorney-fee award under ORS 656.382(1). Thus, I must respectfully dissent from the majority opinion.

At first blush, the Referee's attorney-fee award under ORS 656.386(1) may seem excessive. However, the Referee, having dealt with the parties, is in the best position to judge the quality and efficacy of claimant's counsel's involvement in the claim. I do not advocate second-guessing a referee's attorney-fee award absent compelling reasons to do so. Because the Referee's award in this case was reasonable, taking into consideration all the factors in OAR 438-15-010(4), I would as a matter of policy affirm the Referee's attorney-fee award under ORS 656.386(1).

With regard to the issue of an assessed fee pursuant to ORS 656.382(1), I believe the majority errs in extending SAIF v. Condon, 119 Or App 194 (1993), beyond the facts of that case. The issue in the present case is whether claimant's counsel is entitled to an attorney fee for SAIF's unreasonable resistance to the payment of compensation. The majority does not dispute that SAIF's refusal to timely accept claimant's patellar condition was unreasonable. It denies counsel an attorney fee under ORS 656.382(1), finding that Condon is controlling in this case. I disagree.

In Condon, resistance to the payment of future compensation was not at issue. Rather, the issue was whether a fee was appropriate under ORS 656.382(1), when all compensation had been paid to claimant. Claimant in Condon did not raise, as was done here, the issue of resistance to the payment of future permanent disability. Inasmuch as Condon did not involve the issue presented here, I would not find it controlling. Instead, I would adopt the Referee's reasoning that, since permanent disability is compensation under ORS 656.005(8), SAIF unreasonably resisted the payment of compensation (future permanent disability) when it unreasonably failed to timely accept claimant's patellar condition.

In the Matter of the Compensation of
ROBERT L. WELLS, Claimant
WCB Case Nos. 90-19654 & 90-18739
ORDER ON REMAND (REMANDING)
W. Todd Westmoreland, Claimant Attorney
Employers Defense Counsel, Attorneys
Williams, Zografos, et al., Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. Astleford v. SAIF, 319 Or 225 (1994). In our prior order we affirmed a Referee's order approving a Disputed Claim Settlement (DCS) between claimant, the Department of Insurance and Finance (Department), and the SAIF Corporation as processing agent for the noncomplying employer (NCE). In doing so, we rejected the contention of the NCE that he was entitled to participate in the DCS as a party. Reasoning that the NCE was a party and entitled to participate in the DCS, the Court has remanded for further proceedings.

FINDINGS OF FACT

Claimant filed a claim for a September 1988 left shoulder injury with the NCE. Following an NCE order and the Department's referral, SAIF accepted the claim. See ORS 656.054(1).

Claimant subsequently filed additional claims with the NCE for a left wrist injury and a high blood pressure condition. SAIF processed these claims as part of the accepted left shoulder injury. SAIF issued partial denials of both the left wrist injury and the high blood pressure condition. Claimant filed hearing requests from the denials, and the matter was assigned WCB No. 90-18739.

Meanwhile, claimant filed a separate hearing request from a responsibility disclaimer issued by the NCE. That matter was assigned WCB No. 90-19654 and consolidated for hearing with WCB No. 90-18739.

Claimant, the Department and SAIF then entered into a DCS pursuant to ORS 656.289(4), for the total sum of $28,000, inclusive of attorney fees. Under the terms of the DCS, SAIF issued a "back-up" denial of claimant's left shoulder injury, and claimant requested a hearing from that denial. The DCS further provided that SAIF's denials of the left shoulder injury, the left wrist injury, and the high blood pressure condition were final. Consistent with the terms of the DCS, claimant and SAIF filed a motion for dismissal of the hearing requests filed on these denials. The NCE did not participate in the negotiations or approve the DCS.

On April 26, 1991, the Referee issued an order approving the DCS, thereby dismissing the hearing requests from SAIF's denials.[1] The Board affirmed the Referee's order, concluding that the NCE was not entitled to participate in the DCS.[2] The Court of Appeals disagreed, concluding that

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[1] In that same order, the Referee denied the NCE's motion to join Tillamook County Creamery Association as a party. The Referee also dismissed with prejudice the hearing request from the NCE's responsibility disclaimer.

[2] The Board also denied the NCE's motion to remand for further development of the record regarding the noncompliance issue. In addition, the Board affirmed the Referee's joinder ruling. None of the parties requested review of the Referee's dismissal of the hearing request from the responsibility disclaimer.

claimant, the Department and SAIF could not enter into a valid DCS without the consent of the NCE. Accordingly, the court vacated the Board's order insofar as it approved the DCS. Astleford v. SAIF, 122 Or App 432, 436-439 (1993).[3]

SAIF then petitioned the Supreme Court for review. The Court concluded that the NCE was a "party" who "may * * * by agreement" settle a disputed workers' compensation claim as provided in ORS 656.289(4). Consequently, the Court affirmed the decision of the Court of Appeals and vacated the Board's order insofar as it pertained to the approval of the DCS. Astleford v. SAIF, 319 Or 225 (1994).[4] The Supreme Court remanded for further proceedings.

CONCLUSIONS OF LAW AND OPINION

In its decision in Astleford v. SAIF, supra, the Supreme Court has concluded that the NCE is a party to a DCS under ORS 656.289(4). In light of such a holding, it necessarily follows that the present DCS clearly violates ORS 656.289(4) because the NCE was not a party to the settlement agreement. Consequently, the DCS must be set aside.

Consistent with the Court's ruling, we vacate the Referee's order insofar as it approved the DCS. We remand this matter to Referee Crumme for further proceedings consistent with this order, including reinstatement of the hearing requests from SAIF's denials.

Since we have set aside the April 26, 1991 DCS, and since the settlement proceeds have apparently already been paid, we may authorize an offset for the amount paid by the employer against future permanent disability benefits paid in this claim. See Pruitt Watson, 45 Van Natta 1633 (1993); Steve Maywood, 44 Van Natta 1199 (1992), aff'd mem 119 Or App 517 (1993). Claimant received settlement proceeds in the amount of $28,000, inclusive of attorney fees. Although not paid directly to claimant, the attorney fee portion of the settlement is properly considered a benefit to claimant. See Steiner v. E. J. Bartells Co., 114 Or App 22 (1992); Buck E. Johnson, 45 Van Natta 244 (1993). Accordingly, we authorize an offset in the amount of $28,000.

Accordingly, the Referee's order dated April 26, 1991 is vacated to the extent it approved the DCS and dismissed the hearing requests from SAIF's denials. This matter is remanded to Referee Crumme for further action consistent with this order. Following those further proceedings, Referee Crumme shall issue a final, appealable order.

IT IS SO ORDERED.

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[3] The Court of Appeals also affirmed the Board's ruling on the remand request, reasoning that neither it nor the Board could review the NCE order finding the employer to be noncomplying. The NCE did not appeal the Board's joinder ruling.

[4] The Supreme Court did not allow review of the Court of Appeals' ruling on the remand issue.

Board Member Gunn specially concurring.

In light of the Supreme Court's ruling, I am obliged to conclude that the disputed claim settlement is invalid because the noncomplying employer was not a participant to the agreement. Although I shall fulfill this obligation, I must register my frustration in doing so.

By virtue of the noncomplying employer's failure to provide coverage to claimant (in violation of the workers' compensation statutes), the SAIF Corporation has been statutorily assigned the duty of processing claimant's injury claim. See ORS 656.054(1). With the exception of contesting the compensability of the claim, I submit that the noncomplying employer has forfeited its rights to participate in any claim processing decisions. To do otherwise, essentially places a noncomplying employer in a more authoritative position than an employer who has contracted for workers' compensation coverage. (Since insurers are typically assigned full responsibility for all claim processing decisions.)

I submit that the Supreme Court's decision to treat noncomplying employers as "parties" to a disputed claim settlement is the equivalent of appointing Willie Loman as Chairman of the Federal Reserve. I trust that the Court's opinion (and possibly this concurrence) will form the basis for future legislation designed to eliminate the "special status" that a noncomplying employer presently enjoys in situations such as this.

In the Matter of the Compensation of
MANUEL ALTAMIRANO, Claimant
WCB Case No. 93-06046
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Nichols' order that upheld the insurer's de facto denial of medical services. In his brief, claimant requests that we take administrative notice of the insurer's Respondent's Brief submitted to the Court of Appeals in WCB Case No. 91-00697. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but offer the following brief summary.

In February 1990, claimant, who speaks no English, compensably injured his low back. He was diagnosed with a lumbosacral strain and right sacroiliac strain. (Ex. 1-3). Claimant also reported left leg symptoms. (Ex. 2-1). The insurer accepted a lumbar strain. (Exs. 3 and 21-1). The claim was closed by a September 25, 1990 Determination Order that awarded no permanent disability. The Determination Order was affirmed by a June 3, 1991 Order on Reconsideration.

On October 31, 1990, claimant experienced increased low back pain that radiated into the left leg. A CT scan revealed a bulging disk on the right at L5-S1 and claimant's then-attending physician, Dr. Poulson, reported functional overlay. (Exs. 7 and 8). In December 1990, claimant sought treatment from Dr. Buttler, chiropractor, who treated him for the maximum number of treatments allowed and then referred him to Dr. Mitchell, M.D., who diagnosed a chronic lumbosacral sprain. (Exs. 9, 10, 11 and 12).

Claimant continued to complain of intermittent pain in his low back to the left of midline that radiated into the upper buttock and into the left rib cage that was increased by bending, twisting, lifting and standing for any period of time. (Ex. 14-2). Claimant made a claim for aggravation of his compensable injury. He returned to work and continued to receive conservative treatment from Drs. Mitchell and Buttler.

On August 15, 1991, the insurer denied claimant's aggravation claim and partially denied the disc at L5-S1 on the right and the functional overlay. The insurer also denied claimant's "current condition" on the basis that his compensable strain had resolved and that any current need for treatment or disability was solely due to the disc and/or the functional overlay. (Ex. 21).

In a June 30, 1992 Opinion and Order, Referee Howell set aside the aggravation denial and upheld the partial denials of the right L5-S1 disc, functional overlay and current condition. Referee Howell upheld the current condition denial on the basis that claimant's current condition, i.e., the disc and/or functional overlay, was not causally related to claimant's compensable injury and that claimant's compensable strain condition neither required medical service nor resulted in disability on the date of the denial, August 15, 1991. (Ex. 43).

In an April 14, 1993 Order on Review, the Board affirmed and adopted Referee Howell's order. (Ex. 53A). Claimant appealed the Board's order (WCB Case No. 91-00697) to the Court of Appeals.

The insurer paid all claimant's medical bills incurred prior to August 15, 1991. On the strength of its "current condition" denial and Referee Howell's opinion, the insurer declined to pay for any medical bills incurred after August 15, 1991.

On July 23, 1992, the insurer closed claimant's aggravation claim, declaring him medically stationary on September 25, 1990 and awarding no permanent disability. A December 1, 1992 Order on Reconsideration modified claimant's temporary disability award and affirmed the closure in all other respects.

In a March 22, 1993 Opinion and Order, Referee Garaventa found claimant medically stationary on July 28, 1991, modified claimant's temporary disability award, and awarded 23 percent unscheduled permanent disability. (Ex. 53). This order was affirmed by the Board in a December 3, 1993 Order on Review. This order was not appealed and has become final by operation of law.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

In his brief, claimant requests that we take administrative notice of the insurer's Respondent's Brief and Abstract of Record submitted to the Court of Appeals in WCB Case No. 91-00697 to establish that the insurer has made an argument to the court representing that Referee Howell's order has no preclusive effect. Claimant has attached a copy of the insurer's brief to show the legal arguments made in that case.

We may take administrative notice of those things which are capable of ready determination. ORS 40.065(2); ORE 201(b); Groshong v. Montgomery Ward, 73 Or App 403 (1985). Here, claimant offers an argument made by the insurer in a different proceeding. Inasmuch as the insurer does not contest the accuracy of the submission, we grant claimant's request, but only insofar as acknowledging that such a brief was submitted to the Court of Appeals. We wish to make clear that we in no way take notice of the legal arguments in a case that is not before us. The issues in this case must be decided on the legal arguments made in this case and on the evidence received at hearing. Therefore, we rely exclusively on the record as developed in this case in the hearing below, and on the legal arguments made by the parties in this case. ORS 656.295(5).

Medical Services

Referee Howell, in a prior order, upheld the insurer's "current condition" denial. The "current condition" included an L5-S1 disc and functional overlay, which Referee Howell found noncompensable, as well as a compensable strain condition that did not require treatment or disability as of the date of the denial.[1] On the strength of Referee Howell's order, the insurer declined to pay any medical bills incurred by claimant for medical services subsequent to August 15, 1991.

Here, the Referee concluded that claimant's medical services subsequent to August 15, 1991 were not compensable, on the basis that claimant failed to show a change of condition or that his need for treatment was related to the accepted condition. We disagree.

Although finding that claimant's "current condition" no longer required medical services or disability as of the date of the denial, Referee Howell made no finding as to whether claimant's "current condition" was related to his compensable injury or that his compensable injury would not require medical services or result in disability in the future. Indeed, Referee Howell specifically stated that his finding regarding claimant's current condition had no preclusive effect on claimant's claim for compensation prior to August 15, 1991 or on any claim he might make after that date.

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[1] Claimant also established a compensable aggravation of his low back strain. Referee Howell, in his Opinion and Order, concluded that claimant's functional overlay was not a consequence of his compensable low back injury and that claimant's disc bulge at L5-S1 had not combined with claimant's compensable injury. More importantly for our analysis here, Referee Howell also found that claimant had received medical services for his compensable condition until mid 1991 and then stated:

> "There is no evidence in this record that claimant's "current condition" on August 15, 1991 required medical service or resulted in disability. * * * * [T]he insurer was correct in denying that claimant's injury condition entitled him to any claimed compensation or any benefits for his compensable injury on August 15, 1991. * * * * Such a finding has no preclusive effect on claimant's claim for compensation prior to that date nor does it act as a bar to any claim for compensation subsequent to that time." (Emphasis added).

As a technical matter, Referee Howell should probably have set aside the "current condition" denial to the extent that it denied claimant's compensable back strain. Had he done so, the medical billings at issue most likely would have been paid in the usual course of claim processing. In any event, the scope of Referee Howell's order is so narrow, that all claimant need now do is to show that he needed treatment for his compensable back strain.

We conclude that Referee Howell's order decided only the compensability of claimant's current condition as of August 15, 1991, and that his decision does not bar claimant from litigating the compensability of medical services for his compensable low back condition after that date. In this regard, claimant is only required to show that, once again, he is in need of medical services for his compensable condition.

Subsequent to the Referee's order, the Court of Appeals issued its opinion in Beck v. James River Corp., 124 Or App 484 (1993). The court held that, under ORS 656.245(1), medical services for conditions resulting from a compensable injury are compensable if the need for treatment bears a material relationship to the compensable condition. Id. at 487. Thus, such medical services are compensable even though claimant's treatment may also be partially attributed to a noncompensable injury or condition. See Donald E. Beck, 46 Van Natta 1259, 1260 (1994) (a worker's need for treatment is compensable even if it is attributable to both a noncompensable injury and a compensable injury); Lucky L. Gay, 46 Van Natta 1252 (1994) (a worker's need for treatment is compensable where an intervening, noncompensable incident was the major contributing cause of the need to treat a compensable condition).

Here, the medical evidence and prior litigation establish that claimant has a compensable chronic low back condition as well as a noncompensable bulging disc and noncompensable functional overlay. Dr. Buttler's medical billings indicate that he treated claimant for his chronic lumbosacral sprain and myalgia with concurrent intervertebral disc derangement and transient bilateral sciatica, and cervical and thoracic myofascitis with concurrent left intercostal neuralgia. (Exs. 23, 24, 28, 32, 35 and 40). Dr. Mitchell treated claimant for a lumbar strain, back pain, a herniated disc and reactive depression, either singly or in combination. Dr. Mitchell opined that claimant's chronic back condition was the result of his compensable injury and was the major contributing cause of his pain and need for treatment. (Exs. 51A and 59). Dr. Poulson explained the difference between claimant's noncompensable degenerated disc in the right and the compensable disc joint instability which causes claimant's mostly left-sided symptoms. (See Ex. 24A at 12, 19, 24, 25). Based on this record, we conclude that claimant's medical treatment for his lumbar strain and back pain is materially related to his compensable condition and is, therefore, compensable. See ORS 656.245(1); Beck v. James River Corp., supra.

Claimant is entitled to an assessed attorney fee for prevailing on the medical services issue. ORS 656.386(1); Gwen A. Jackson, 46 Van Natta 822 (1994). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the medical services issue is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated November 16, 1993 is reversed. The insurer's de facto medical services denial insofar as it relates to the chronic low back condition is set aside. The claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
GUSTAVO CANTU-RODRIGUEZ, Claimant
WCB Case No. 93-07585
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Mills' order which: (1) assessed an attorney fee under ORS 656.382(1) in the amount of $750 for its allegedly unreasonable resistance to the payment of compensation; and (2) awarded claimant's counsel an "out-of-compensation" attorney fee under ORS 656.386(2), to be paid out of future compensation. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's finding of fact, with the following supplementation.

Claimant requested review of the prior Referee's March 8, 1993 order, which denied claimant's request for attorney fees under ORS 656.382(1) for SAIF's allegedly unreasonable issuance of a notice of ineligibility for vocational assistance on August 27, 1992. On review, the Board affirmed the Referee's order, reasoning that, although SAIF's conduct was unreasonable, it was unable to find that SAIF's issuance of the notice of ineligibility constituted "resistance to the payment of compensation" under ORS 656.382(1). Gustavo Cantu-Rodriguez, 45 Van Natta 2322 (1993), on recon 46 Van Natta 24 (1994).

CONCLUSIONS OF LAW AND OPINION

ORS 656.382(1) Attorney Fee

Claimant has an accepted low back claim. He received a second notice of ineligibility for vocational assistance in April 1993. (Ex. 17). Claimant requested review by the Director. The Director issued an order setting aside the notice of ineligibility and directing SAIF to determine claimant's eligibility for vocational assistance at the proper time. (Ex. 22). Claimant then requested a hearing, seeking attorney fees.

The Referee awarded an attorney fee under ORS 656.382(1), holding that when a carrier resists the present entitlement to benefits associated with an accepted claim, an attorney fee may be awarded under ORS 656.382(1) if such conduct is unreasonable. The Referee reasoned that an interpretation that attorney fees can be assessed under ORS 656.382(1) only when compensation is presently due and payable would render the statute meaningless, since the sole avenue for assessing an attorney fee when amounts are due is under ORS 656.262(10). See Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992). We agree with the Referee's reasoning and offer the following supplementation.

We have previously addressed the same issue presented here in Cantu-Rodriguez, supra. In our prior order, on reconsideration, we questioned whether SAIF's conduct in prematurely issuing a notice of ineligibility for vocational assistance, although unreasonable, constituted "resistance to the payment of compensation" within the meaning of ORS 656.382(1). We now revisit the issue and conclude that SAIF's conduct, under the circumstances of this case, constitutes unreasonable resistance to the payment of compensation within the meaning of ORS 656.382(1).

ORS 656.382(1) provides for a reasonable attorney fee "[i]f an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation." Attorney fees under this section do not depend on whether there are any "amounts then due." Eastmoreland Hospital v. Reeves, 94 Or App 698, 703 (1989). However, if a carrier unreasonably refuses to pay compensation which is due, the remedy for penalties and attorney fees is under ORS 656.262(10). The same conduct for which penalties and fees are assessed under ORS 656.262(10) cannot be the basis for attorney fees under ORS 656.382(1). Martinez, supra. In delineating the respective spheres of the two statutes, the court has affirmed the continuing vitality of ORS 656.382(1). See Oliver v. Norstar, Inc., 116 Or App 333, 336 (1992); Martinez, supra, 114 Or App at 456. Thus, we conclude that, when no compensation is due, penalties and attorney fees cannot be assessed under ORS 656.262(10), but attorney fees may be assessed under ORS 656.382(1).

We summarize the requirements for assessing an attorney fee under ORS 656.382(1) as follows: (1) a compensable claim; and (2) unreasonable conduct; which (3) results in resistance to the payment of compensation. Ellis v. McCall Insulation, 308 Or 74 (1989); SAIF v. Condon, 119 Or App 194 (1993); Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991); see also Cantu-Rodriguez, supra, 46 Van Natta at 24.

We apply these criteria to the present case. Here, the underlying low back claim is compensable. In addition, the Referee found that SAIF's conduct in issuing a premature notice of ineligibility for vocational services, which had no legal basis, was unreasonable. Opinion and Order at 2-3; (see Ex. 22-2). We agree and adopt that portion of the order. We turn now to the remaining question: whether SAIF's unreasonable conduct resulted in resistance to the payment of compensation within the meaning of ORS 656.382(1).

We summarize the pertinent facts. In April 1993, SAIF notified claimant that he was ineligible for vocational assistance because he was not available in Oregon to participate in evaluation of his eligibility. (Ex. 17). The letter further advised claimant that if he was dissatisfied with SAIF's action, he must contact the Department within 60 days or lose his right to appeal this decision. (Id). Claimant, through his attorney, timely requested Director review. (Ex. 19).

On June 16, 1993, the Director issued an order finding that it was premature to determine claimant's eligibility for vocational assistance, and that the vocational rules do not require a worker to be available in Oregon in order to participate in eligibility determination. (Ex. 22). The Director ordered SAIF to redetermine claimant's eligibility within 30 days of receiving notice of his permanent restrictions. (Ex. 22-2).

SAIF contends that the premature notice of ineligibility had no effect on claimant's entitlement to vocational benefits. SAIF contends that even if claimant had not contested its decision, claimant would still have been eligible for redetermination when he became medically stationary and permanent restrictions were established. Thus, SAIF argues that its conduct did not constitute resistance to the payment of compensation because it had no effect on claimant's entitlement to benefits. Furthermore, SAIF contends that since no compensation is presently due as a result of the Director's order, its conduct could not constitute resistance to the payment of compensation within the meaning of ORS 656.382(1). We disagree.

Contrary to SAIF's assertion, we find that its issuance of the notice of ineligibility was not a meaningless act that had no effect on claimant's entitlement to vocational benefits. Had the notice of ineligibility become final, claimant may not have been necessarily precluded from reestablishing eligibility later. However, in order to restore his entitlement to vocational assistance, claimant would eventually have to overcome the determination of ineligibility. Therefore, as a result of SAIF's conduct, claimant's burden of proving entitlement to vocational benefits would be greater than it would be absent the ineligibility determination. We reach this conclusion based on the vocational claim processing provisions of ORS 656.340 and the Director's vocational assistance rules.

Absent a determination of ineligibility, the carrier is required, under certain circumstances, to determine eligibility for vocational assistance. See ORS 656.340(1) through (4); OAR 436-120-035(1), (4). It is the carrier's responsibility to determine a worker's likely eligibility for vocational assistance upon receipt of a request for assistance, a medical report indicating the need for assistance, or after 90 consecutive days of time loss. OAR 436-120-035(1). Thus, initially, the carrier is required to proceed with investigating and evaluating the worker's eligibility for vocational assistance.

By contrast, once a worker has been determined ineligible for vocational assistance, the responsibility for re-establishing eligibility, as a practical matter, shifts to the worker. For example, the carrier is no longer required to contact a worker within five days of learning that the worker is medically stationary to determine eligibility for vocational assistance, if an eligibility determination has been previously made. See OAR 436-120-035(5).

In addition, once a worker has been determined ineligible, redetermination can only be done under the conditions set forth in OAR 436-120-055. That rule requires an insurer to redetermine

eligibility for a worker who has been previously determined ineligible only under specified conditions. Those conditions include, inter alia, the following which may be applicable in this case: (1) that the worker, for good cause, was not available for vocational assistance; and (2) that the insurer erred in its previous eligibility determination. OAR 436-120-055(2)(c), (d). Thus, a worker who has been previously determined ineligible, must establish at least one of the circumstances under which a carrier must redetermine eligibility under OAR 436-120-055, in order to compel the carrier to act.

Here, had claimant allowed the ineligibility determination to become final, he would later have to establish, in order to compel redetermination, either that (1) for good cause, he was unavailable for vocational assistance, or (2) SAIF erred in its previous determination. To do so, he may very well require attorney assistance to establish a basis for redetermination. Whereas, had SAIF not issued the erroneous notice of ineligibility, claimant would have remained automatically entitled to a determination of eligibility at the proper time.

We recognize that a determination of ineligibility does not prevent redetermination under the same opening of the claim, if the carrier receives new information that would change the eligibility determination. ORS 656.340(1)(c). Nevertheless, once a worker has been found ineligible for vocational assistance, the responsibility for obtaining vocational assistance shifts to the worker; whereas absent an ineligibility determination, the carrier has the affirmative duty to proceed with evaluation of eligibility. We interpret the practical effect of the Director's rules to be that once a worker has been determined ineligible under the current opening of the claim, the carrier no longer has a duty to investigate or evaluate eligibility, unless claimant establishes a basis for redetermination.

Under these circumstances, we find that SAIF's conduct, in issuing a baseless and premature notice of ineligibility for vocational assistance, created an unwarranted impediment to claimant's receipt of vocational assistance. We further find that SAIF's conduct constitutes resistance to the payment of compensation within the meaning of ORS 656.382(1). We make this finding particularly in light of the legislative intent to remove, as much as possible, vocational assistance matters from the adversarial process. See SAIF v. Severson, 105 Or App 67, 70 n.1 (1990). SAIF's conduct, by increasing claimant's burden of establishing entitlement to vocational assistance, tends to promote, rather than reduce, litigation. Therefore, we affirm that portion of the Referee's order which assessed an attorney fee under ORS 656.382(1).

SAIF also contends that no attorney fee can be assessed under ORS 656.382(1) because the Director's order resulted in no compensation to claimant. SAIF's argument is premised on the proposition that the determination of eligibility for vocational assistance does not itself constitute "vocational assistance," for which it cites the Director's rule defining "vocational assistance." See OAR 436-120-005(12).

We do not find the Director's rule defining "vocational assistance" to be controlling in this situation. That definition is specifically intended for construing the Director's vocational assistance rules, and should be applied in that context. OAR 436-120-005.

However, the question in the present case is whether SAIF unreasonably resisted the payment of compensation within the meaning of ORS 656.382(1). In SAIF v. Severson, supra, the court recognized that vocational assistance constitutes "compensation" within the meaning of ORS 656.382(1). See also ORS 656.005(8) ("compensation" includes "all benefits *** provided for a compensable injury to a subject worker *** by an insurer *** pursuant to this chapter"). The statutory language does not distinguish between services for determining eligibility and other vocational services; both are referred to as "vocational assistance." ORS 656.340(4). Thus, in the context of this case, we conclude that "vocational assistance" compensation includes services for evaluating eligibility for vocational assistance. Accordingly, we conclude that the court's decision in Severson, supra, is applicable to this case and authorizes the assessment of an attorney fee under ORS 656.382(1).

SAIF argues that the Referee's order is contrary to Randall v. Northwest Ins. Corp., supra, and our decision in Jeffrey D. Ward, 45 Van Natta 1513 (1993). We disagree. In both cases, the request for attorney fees under ORS 656.382(1) was denied because the underlying claim was found not compensable. Here, however, the underlying claim itself is compensable, and the Director's order resulted in reinstatement of claimant's entitlement to vocational assistance in the form of evaluation of

eligibility. Thus, we conclude that neither decision requires that we reverse the Referee's assessment of an attorney fee under ORS 656.382(1) in the present case.[1]

Finally, SAIF contends that the attorney fee assessed by the Referee is excessive. We disagree. After our review of the record, we agree with the Referee's determination that, under the circumstances of this case, a fee in the amount of $750 is appropriate.

ORS 656.386(2) Attorney Fee

We adopt and affirm that portion of the Referee's order which approved an "out-of-compensation" attorney fee under ORS 656.386(2), to be paid out of claimant's future temporary disability benefits, if any, resulting from any subsequent conclusion that claimant was eventually entitled to vocational services.

ORS 656.382(2) Attorney Fee

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee award for his counsel's services on Board review in defending the Referee's attorney fee awards. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 4, 1993 is affirmed.

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[1] Neither do we find that the court's decisions in Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), or SAIF v. Condon, 119 Or App 194, rev den 317 Or 13 (1993), prohibit the assessment of an attorney fee in this case. In both cases, the court held that an insurer cannot resist the payment of compensation that has been paid. In both cases, the conduct of the insurers did not result in resistance to the payment of compensation because, despite inappropriate claims processing, the insurers had timely paid all the benefits at issue. Here, by contrast, SAIF has not already authorized or paid for an evaluation of claimant's eligibility for vocational assistance. Instead, we have found that SAIF's conduct created an impediment to claimant's obtaining vocational assistance in the future. We do not find the court's decisions in Jackson and Condon to be controlling here.

Board Member Hall specially concurring.

As one of the signators to the Board's order in Gustavo Cantu-Rodriguez, 45 Van Natta 2322 (1993), on recon 46 Van Natta 24 (1994), I write separately to clarify the evolution of my analysis concerning this issue. In declining to award an attorney fee under ORS 656.382(1) in our first decision, I was persuaded that SAIF's conduct was unreasonable. Nevertheless, since I found no basis to conclude that such conduct constituted an unreasonable resistance to the payment of compensation, I concluded that I was without authority to award a carrier-paid attorney fee under ORS 656.382(1). The rationale contained in today's majority decision provides the analysis to support a conclusion that SAIF unreasonably resisted the payment of compensation. Inasmuch as I concur with such reasoning, I now have the statutory authority to assess an attorney fee award to address such conduct.

Board Members Neidig and Haynes dissenting.

We respectfully dissent from the Board's decision awarding claimant a carrier-paid attorney fee award under ORS 656.382(1). We base this conclusion on the following reasoning.

As recognized by the majority, an attorney fee award under ORS 656.382(1) is available provided that a carrier unreasonably resists the payment of compensation. Considering the Director's finding that the SAIF Corporation's notice of eligibility for vocational assistance was premature, the majority acknowledges that claimant is not currently entitled to vocational assistance. Nevertheless, the majority reasons that SAIF's conduct satisfies the statutory prerequisite for an attorney fee award because it could potentially impede claimant's future eligibility for vocational assistance.

We submit that such reasoning is both speculative and insufficient to constitute an unreasonable resistance to the payment of compensation. In order to make such a "resistance" finding, the claim must be compensable. Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991), Margaret Boehr, 44 Van Natta 2565 (1992); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Furthermore, where compensation has been paid despite a carrier's unreasonable conduct, there cannot be an unreasonable resistance to the payment of compensation. SAIF v. Condon, 119 Or App 194 (1993); Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991).

Here, claimant's claim is for vocational assistance. The Director has neither awarded claimant vocational benefits nor has SAIF provided such compensation.[1] To the contrary, the Director has expressly ruled that it would be premature to render such a determination.

Thus, since claimant has not been found entitled to vocational benefits, there has been no compensation payment for SAIF to have resisted. However, should claimant subsequently receive vocational benefits, SAIF's prior conduct would likely represent an unreasonable resistance to the eventual payment of that compensation. Yet, as circumstances presently exist, just as SAIF's eligibility determination was found premature, so is claimant's request for an attorney fee award under ORS 656.382(1).[2]

Postponement of consideration of claimant's "382(1)" attorney fee request will not preclude claimant from eventually recovering such an award. Inasmuch as there is no statutory deadline for bringing such a request, claimant may seek this attorney fee when, and if, he receives vocational assistance benefits.

Such a result does not reward SAIF for allegedly unreasonable behavior. Should claimant wish to deter such conduct, he may wish to notify the Director. If the Director finds that the conduct represents a pattern of claim processing in violation of statutory and administrative prerequisites, a civil penalty may be assessed. ORS 656.745(3).

These procedures accomplish the primary goals advanced by claimant's appeal in a manner entirely consistent with the statutory scheme and controlling case precedents. First, SAIF's claim processing decisions can be presented to the administrative body authorized to regulate and police such actions. Secondly, in the event that claimant's vocational assistance claim is eventually granted, claimant can present his request for penalties pursuant to ORS 656.262(10) and/or attorney fees under ORS 656.382(1).

We can appreciate the majority's desire to discourage conduct which it considers inconsistent with statutory and administrative rules. However, such conduct must likewise be considered and punished in a manner consistent with those same regulatory requirements. In this instance, because the majority's decision exceeds the Board's statutory authority, we must respectfully dissent from that portion of the order that awards an attorney fee under ORS 656.382(1).

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[1] This conclusion is supported by OAR 436-120-005(12), which provides that vocational assistance does not include activities for determining a worker's eligibility for vocational assistance.

[2] The majority relies on SAIF v. Severson, 105 Or App 67 (1990), for the proposition that services rendered for merely evaluating a claimant's eligibility for vocational assistance (as distinguished from a decision actually ordering that such assistance be provided) constitutes "compensation" within the meaning of ORS 656.382(1). Since that particular question was not presented to the court, we are not prepared to share the majority's extrapolation of the Severson decision. In fact, we disagree with the majority's interpretation for the following reasons.

First, in Severson, the claimant was actually granted vocational assistance by the Director. Thus, the court's conclusion that the Board is authorized to award an attorney fee under ORS 656.382(1) for an unreasonable resistance to the payment of compensation is necessarily premised on the fact that the Director had directed the carrier to provide vocational services. Since in the present case the Director did not find that claimant was entitled to such services, the Severson holding provides no support for the majority's attorney fee award.

Secondly, the Severson holding must be analyzed within the context of other appellate decisions addressing ORS 656.382(1) and the concept of "unreasonable resistance to the payment of compensation." Those other decisions supported an attorney fee award under ORS 656.382(1) provided that compensation had been unpaid. See Aetna Casualty Company v. Jackson, supra; Randall v. Liberty Northwest Ins. Corp., supra. These holdings, as well as the court's rulings which have subsequently followed, do not support a conclusion that an unreasonable delay in the adjudication of a claim will automatically result in a finding of unreasonable resistance to the payment of compensation. To the contrary, where all compensation has already been paid or where no compensation has been awarded, the statutory predicate for an attorney fee award has not been satisfied. SAIF v. Condon, supra; Boehr v. Mid Willamette Valley Food, supra; Jerry D. Hemenway, 45 Van Natta 1466 (1993).

In the Matter of the Compensation of
FREIDA L. ERNEST, Claimant
WCB Case No. 93-11389
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Members Westerband and Hall.

The SAIF Corporation requests review of Referee Emerson's order that increased claimant's unscheduled permanent disability award from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to 15 percent (48 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant, who is five feet two and weighs about 125 pounds, is a Certified Nurse's Aide. She worked for five years at Fairview Training Center where one of her duties was to physically escort patients from one location to another.

Claimant had no musculoskeletal problems prior to about 1990, when she caught a person who was falling out of a wheelchair. She immediately experienced pain in the right posterior shoulder and right side of her neck. She has had problems in the same area ever since. (Exs. 3 and 14).

In June 1991, claimant was escorting a patient when she was grabbed by the hair, jerked around and her head banged against a wall. A similar incident occurred between September 1991 and February 1992. (Ex. 6-1).

On February 18, 1992, claimant was escorting a patient with arms linked when the patient experienced a seizure and fell. The patient dragged claimant to the ground when she fell, twisting claimant by the neck. (Tr. 6). Claimant experienced pain in the neck, upper back and both shoulders. (Exs. 2, 3 and 6). Claimant was examined by Dr. Hubbard, who diagnosed chronic soft tissue pain in the neck and shoulders and chronic bursitis (impingement syndrome) in the shoulders. (Ex. 3).

A cervical/thoracic strain was accepted by SAIF on May 28, 1992. (Ex. 4).

On July 8, 1992, claimant was lifting and stretching her arms, which increased pain in the neck, shoulders and arms. (Ex. 7-1).

On July 27, 1992, Dr. Ayers evaluated claimant for SAIF. Dr. Ayers diagnosed cervical and shoulder strains by history, an impingement syndrome in the shoulders, and degenerative joint disease in the cervical spine, shoulders and upper extremities. He suspected generalized osteoarthritis. He attributed the impingement syndrome to claimant's protective reaction to her neck and thoracic pain. (Exs. 6 and 7).

On October 31, 1992, claimant was physically escorting two women from one building to another. The two women pulled her arms in opposite directions, affecting her neck and shoulders, particularly on the right. (Tr. 7). SAIF accepted this incident as part of the February 18, 1992 incident. (Tr. 3).

On January 18, 1993, Dr. Gifford released claimant to modified work with a lifting limit of 10 pounds effective December 29, 1992.

On January 21, 1993, claimant was examined by Dr. Boyd, orthopedic surgeon, who found mild degenerative changes at C6-7 but otherwise a normal neck and shoulders by x-ray. (Ex. 9).

On January 25, 1993, Dr. Ayers again examined claimant for SAIF to determine whether the October 31, 1992 incident was a new injury or an exacerbation of her February 18, 1992 injury. He concluded that it was a worsening of the February injury. He found little change in neck range of motion from his July 1992 examination. He opined that claimant's current condition was primarily related to her underlying and preexisting degenerative joint disease of the cervical spine and underlying osteoarthritic problems. He also opined that claimant had no permanent residual impairment as a result of her cervical strain. (Ex. 10).

Claimant became medically stationary on January 25, 1993.

On January 27, 1993, Dr. Gifford, claimant's treating chiropractor, concurred with Dr. Ayers' opinion and released claimant to regular work. (Ex. 11).

SAIF issued a Notice of Closure on February 26, 1993 that awarded no permanent disability. (Ex. 12). Claimant requested reconsideration and a medical arbiter's examination. (Ex. 13).

On August 9, 1993, Dr. Becker performed an arbiter's examination. He found reduced range of motion in claimant's neck, mild degenerative changes at C6-7, and normal shoulder joints. He diagnosed cervicodorsal strain symptoms with underlying cervical spondylosis and mild rotator cuff impingement. He concluded that claimant was not capable of doing repetitive work above the shoulder level greater than light work but opined that the work restrictions and impingement findings were not related to her industrial injury. (Ex. 14). On August 30, 1993, Dr. Scheinberg examined claimant's thoracic range of motion for the director. (Ex. 15).

A September 1, 1993 Order on Reconsideration awarded claimant 14 percent unscheduled permanent disability, based on Dr. Becker's impairment findings in the neck only. (Ex. 16).

On December 8, 1993, Dr. Becker opined in a "check the box" opinion provided by SAIF that the permanent disability identified in his arbiter's examination was not due to the accepted conditions (i.e., not due to the February 18, 1992 work injury). (Ex. 22).

On December 18, 1993, Dr. Gifford disagreed with Dr. Becker's opinion and opined that claimant's injury was the major contributing cause of her permanent impairment, explaining that claimant's degenerative spondylosis was not new and was not the major contributing factor in her disability. (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

The threshold issue here is whether claimant's reduced range of motion in the neck was caused by her accepted February 18, 1992 and October 31, 1992 injuries. The Referee concluded that claimant's cervical impairment was due to her accepted injuries and found claimant entitled to 15 percent unscheduled permanent disability based on the arbiter's impairment findings.

Relying on the December 7, 1993 opinion of Dr. Becker, who had provided the arbiter's report to the Director in August 1993, SAIF argues that claimant's impairment is not attributable to the compensable injury. Claimant contends that by the time a case gets to the medical arbiter, compensability has been established, the arbiter's report is to be used for impairment findings only and arbiter comments regarding compensability are not valid. We conclude that claimant is not entitled to an unscheduled permanent disability award for her neck, and reverse.

Although ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report itself, Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), we do not agree that an arbiter's report must be used for impairment findings only. Rather, we have previously concluded that, where the issue is whether the claimant's permanent disability is "due to the compensable injury" under ORS 656.214(5), the evidentiary restrictions for establishing impairment found in ORS 656.245(3)(b)(B) do not apply, as such "causation" evidence relates to the threshold question of compensability. See Frank H. Knott, 46 Van Natta 364 (1994).

In Knott, we considered post-reconsideration opinions from claimant's attending physician, the medical arbiter and an examining physician. We assumed, without deciding, that the reports from the attending physician and the medical arbiter could be considered for both impairment and causation purposes, citing ORS 656.268(7) and Pacheco-Gonzalez v. SAIF, supra. Moreover, we concluded that ORS 656.245(3)(b)(B) did not apply to prevent our consideration of an examining physician's post-reconsideration order opinion on causation. Frank H. Knott, supra at 365.

Consequently, we may consider Dr. Becker's letter on the question of whether claimant's unscheduled permanent disability is due to her compensable cervical/thoracic strain.[1]

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[1] We point out that at hearing, claimant made no objection to the admission or consideration of Dr. Becker's December 7, 1993 letter as contrary to the evidentiary limitation found in ORS 656.268(7). Rather, at hearing, and on Board review, claimant simply argues that Dr. Becker's opinion was unpersuasive when compared with the contrary opinion of Dr. Gifford. (Tr. 4).

It is claimant's burden to prove by a preponderance of the evidence the nature and extent of any permanent disability due to her compensable injury. ORS 656.266. A worker is entitled to a value under the rules only for those findings of impairment that are permanent and were caused by the accepted injury and/or its accepted conditions. ORS 656.214(5); OAR 436-35-007(1).

Thus, although compensability of claimant's cervical/thoracic strain was established when SAIF accepted that condition, claimant must nevertheless prove that the permanent impairment findings were caused by her accepted condition. ORS 656.214(5); OAR 436-35-007(1).

Here, Drs. Ayers, Gifford and Becker offered opinions regarding whether claimant's permanent disability was due to the compensable injury.

In January 1993, Dr. Ayers opined that claimant's current condition was primarily related to her underlying, preexisting degenerative joint disease and osteoarthritis. He also opined that claimant had no permanent residual impairment as a result of her accepted cervical and thoracic strains. Dr. Gifford concurred with Dr. Ayers' opinion and released claimant to regular work.

In August 1993, Dr. Becker performed an arbiter examination in which he measured reduced range of motion in claimant's neck. In December 1993, in response to a query from SAIF, Dr. Becker opined that the permanent disability he identified in his examination was not due to the accepted conditions in the claim and that it was medically probable that there was no impairment due to the February 18, 1992 injury. Dr. Becker offered no explanation for the appearance of an inconsistency between his willingness to make findings of permanent impairment and his subsequent opinion that the impairment found was not caused by claimant's injury. Consequently, we do not find his opinion on causation persuasive and we do not rely on it. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Somers v. SAIF, 77 Or App 259 (1986); see also Marta I. Gomez, 46 Van Natta 1654 (1994) (The persuasiveness of a "check the box" opinion depends upon the persuasiveness of the foundation upon which the opinion is based).

In his response to Dr. Becker's opinion on causation, Dr. Gifford opined that claimant's preexisting degenerative cervical spondylosis was not the major contributing factor in her disability. He explained that claimant's numerous work injuries in all probability worsened her underlying cervical spondylosis and that the major factor contributing to her present impairment was the accepted injury. (Ex. 23). However, Dr. Gifford failed to explain his change of opinion from the view that claimant had no permanent residual impairment as a result of her cervical strain. Consequently, we also find Dr. Gifford's opinion unpersuasive. Moe v. Ceiling Systems, supra; Somers v. SAIF, supra.

As neither medical opinion is persuasive on the issue of the cause of claimant's impairment, we conclude that claimant has failed to prove by a preponderance of the evidence that her permanent disability is a result of her accepted injury. ORS 656.266.

ORDER

The Referee's order dated January 25, 1994 is reversed. The September 1, 1993 Order on Reconsideration is set aside. The February 26, 1993 Notice of Closure awarding claimant no permanent disability is reinstated and affirmed.

Board Member Hall specially concurring.

On this record, as developed, I agree medical causation has not been established. I write separately, however, to address my concern on an issue of practice and procedure.

This concern has to do with what appears to me to be an abuse of the role of the medical arbiter in these proceedings. ORS 656.268(7) provides in pertinent part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. * * * * The findings of the medical arbiter * * * shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure."

The medical arbiter is appointed by the director and serves as an agent of the director. ORS 656.268(7) and OAR 436-10-047(3). This agency includes reporting directly to the department. Moreover, we know from the court's decision in Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994), that one legislative purpose of the 1990 changes to the workers' compensation laws was to provide for arbiters to resolve disagreements over the rating of disability in claim closures, thus reducing reliance on independent medical examinations and making an impact on the pervasive and expensive problem of "duelling doctors." From the statute, legislative history and the court's discussion in Koitzsch, I reach the conclusion that there is an intent to preserve the autonomy and independence of the arbiter from interference by the parties.

I recognize that in Frank H. Knott, supra, the Board said that post-reconsideration medical opinions regarding causation may be considered by the Referee and the Board. My concern, however, is that in allowing the medical arbiter to be pulled into a post-reconsideration debate on causation and by allowing the arbiter to be utilized in this role, we permit the autonomy and independence of the arbiter to be violated.

While it is not clear under current statutes or regulations that we have the authority to prohibit the practice of subsequent ex parte contact with arbiters, I am nevertheless concerned that this practice violates the purpose of the legislature's establishment of the medical arbiter in the first instance. Indeed, as soon as a medical arbiter has made her or himself available to any party, the medical arbiter is no longer an agent of the director and is no longer playing a neutral role. Instead, the arbiter has become yet another "duelling doctor." Consequently, the opinions of such a physician will be weighed accordingly.

In the Matter of the Compensation of
JOHN L. HAMMERSMITH, Claimant
WCB Case No. 93-10141
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Podnar's order that awarded no unscheduled permanent disability, whereas an Order on Reconsideration had awarded claimant 16 percent (51.2 degrees) unscheduled permanent disability for his low back condition. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, based on inconsistencies in the record and invalid test results noted during the self-insured employer's medical examinations, claimant has not established impairment of his low back. We disagree.

In January 1993, Dr. Parsons, treating physician, found claimant medically stationary. (Exs. 37, 38). He diagnosed chronic lumbar strain and recommended that claimant not lift more than 25 pounds. (Ex. 37-1) Parsons later recommended that claimant not lift more than 20 pounds. (Ex. 46).

In August 1993, claimant was examined by a panel of three medical arbiters. The panel found claimant's lumbar range of motion to be: flexion, 18 degrees; extension, 16 degrees; right lateral flexion 21 degrees; and left lateral flexion 18 degrees. (Ex. 48-2). We conclude that, based on those findings, coupled with Dr. Parsons' limitations regarding claimant's weight-lifting duties, claimant is entitled to a disability award of 16 percent. See OAR 436-35-036(7)-(9).

The employer asserts that we should discount the medical arbiter panel's findings in light of the employer's medical examinations and a physical capacities evaluation (PCE), in which the examiners found that claimant had invalid lumbar range of motion findings, based on inconsistencies and positive Waddell's testing that revealed symptom magnification. (Exs. 19, 40, 41). We disagree.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). In that case, the court held that ORS 656.245(3)(b)(B) prohibits the use of carrier-requested medical examinations to impeach the impairment findings of a claimant's attending physician. See Libbett v. Roseburg Forest Products, 130 Or App 50 (1994) (stating that Koitzsch held that ORS 656.245(3)(b)(B) was intended to eliminate Board's reliance on carrier-requested medical examinations for any purpose in its evaluation of a worker's disability). We have applied the Koitzsch holding to prohibit the use of a physical therapist's testimony to impeach the impairment findings of a medical arbiter. Jerome D'Arcy, 46 Van Natta 416 (1994).

Here, the employer seeks to use its medical examinations and a PCE, which revealed claimant's tendency to exaggerate his symptoms, for the purpose of establishing that claimant's impairment findings during the medical arbiter examination were invalid. In other words, the employer seeks to use the examination results it procured to impeach the medical arbiter panel's impairment findings. Because we would violate the Koitzsch rule if we received and considered the impairment findings contained in the employer's medical reports, we will not consider those findings in determining claimant's impairment.

In reaching this conclusion, we recognize the distinction between offering a carrier's medical examiner's impairment findings to impeach the findings of an attending physician or medical arbiter, rather than as evidence pertaining to the validity of the attending physician's or medical arbiter's impairment findings. However, Koitzsch makes no such distinction, and neither will we.

Furthermore, we recognize that the Court of Appeals has very recently held that Koitzsch does not preclude the Board's use of non-medical evidence in the evaluation of the medical evidence or of a claimant's disability. Libbett v. Roseburg Forest Products, supra, 130 Or App at ____ . However, because the evidence at issue in this case, viz., the employer's medical experts' validity findings, is medical evidence, we conclude that the Libbett exception does not apply.

Relying on Patsy R. Butterfield, 45 Van Natta 1096 (1993), the employer argues that, because the medical arbiter panel did not specifically consider claimant's tendency to magnify his symptoms, we should afford the panel's opinion minimal weight. In Butterfield, we gave minimal weight to the attending physician's opinion rendered without knowledge that the claimant tended to exaggerate her physical restrictions. In doing so, we relied, in part, on the validity findings of the carrier's medical expert. We did not, however, have the benefit of Koitzsch in that case. Therefore, to the extent that Butterfield conflicts with Koitzsch, we are no longer at liberty to rely on it, and we decline to do so here.

Claimant's attorney is entitled to an assessed fee under ORS 656.382(2) because the employer requested a hearing on the Order on Reconsideration, and the Board has subsequently concluded that claimant's permanent disability compensation should not be disallowed or reduced. Thus, claimant has ultimately successfully defended against the employer's hearing request which attempted to reduce or eliminate claimant's permanent disability award granted by the Order on Reconsideration.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing concerning the permanent disability issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated November 30, 1993 is reversed. The Order on Reconsideration award of 16 percent (51.2 degrees) unscheduled permanent disability is reinstated and affirmed. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. For services at hearing regarding the employer's unsuccessful appeal of the Order on Reconsideration, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
JEFFREY R. HOOD, Claimant
WCB Case No. 93-11421
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Hoquet's order that affirmed an Order on Reconsideration classifying claimant's neck injury claim as nondisabling. On review, the issue is claim classification.

We adopt and affirm the Referee's order with the following supplementation.

On review, claimant asserts that, because he is not yet medically stationary, he need only prove a "substantial likelihood" of entitlement to permanent disability in order to show that his claim properly is classified as disabling. See OAR 436-30-045(5)(c).

We first note that we have applied OAR 436-30-045(5) to determine appropriate claim classifications. E.g., Walter T. Driscoll, 45 Van Natta 391, 392 (1993). Under that rule, a claim is disabling when, in relevant part, the worker is medically stationary and entitled to permanent disability or, if not medically stationary, there is a substantial likelihood of entitlement to permanent disability.

We first disagree with claimant that he is not medically stationary. Claimant injured his neck during a March 4, 1993, motor vehicle accident. On that date, Dr. Moshofsky, M.D., who initially treated claimant, diagnosed mild cervical strain and a mild scalp contusion. (Ex. 8-4). On April 1, 1993, claimant was examined by Dr. Patricelli, M.D., who found him "not medically stable." (Ex. 3A-2).

Claimant primarily was treated by Dr. Fetter, chiropractor. On August 4, 1993, claimant's last appointment, Dr. Fetter indicated that claimant was "approaching mmi." (Ex. 2A-5).

On November 12, 1993, Dr. Duff, orthopedist, examined claimant on behalf of the SAIF Corporation. Dr. Duff noted that claimant had received no treatment since August 20, 1993, and that he had "done well" until shortly before the examination, when he began experiencing recurrent headaches. (Ex. 11-2). Dr. Duff found that claimant's cervical strain was medically stationary and that additional medical treatment was not indicated. (Id. at 5).

In light of Dr. Fetter's chartnote that claimant was approaching maximum improvement and Dr. Duff's report, we find that claimant was medically stationary as of the examination with Dr. Duff. See ORS 656.005(17) (defining "medically stationary" as "no further material improvement would reasonably be expected from medical treatment, or the passage of time"). Because claimant is medically stationary, he must show entitlement to permanent disability in order for his claim to be classified as disabling. See OAR 436-30-045(5)(b).

We also agree with the Referee that claimant did not prove entitlement to permanent disability. Along with the Referee's reasoning, we note that, although Dr. Fetter answered "yes" in a "check-the-box" report to a question regarding whether claimant suffered from a chronic condition limiting repetitive use of his neck, shoulders, and midback, he personally added that claimant would "experience periodic episodes of soreness, stiffness and headache which will require chiropractic treatment" which would be a "permanent condition." (Ex. 9-3). Based on this notation, we find that, at most, Dr. Fetter predicted that claimant would experience a waxing and waning of symptoms requiring palliative care. Inasmuch as such an opinion does not qualify as evidence that claimant is unable to repetitively use a body area due to a chronic and permanent condition, we disagree with claimant that Dr. Fetter proved such impairment. See former OAR 436-35-320(5); David A. Kamp, 46 Van Natta 389, 390 (1994) (evidence of a chronic condition is not proof that claimant is unable to repetitively use a body area).

Finally, we note that claimant has not suffered any temporary disability (time loss) as a result of the compensable injury.

ORDER

The Referee's order dated January 20, 1994 is affirmed.

In the Matter of the Compensation of
ROGER D. JOBE, Claimant
WCB Case Nos. 92-15112 & 92-10152
SECOND ORDER ON RECONSIDERATION
Gary D. Taylor, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

The SAIF Corporation, on behalf of R. Keith Foster, a noncomplying employer, requests reconsideration of our May 6, 1994 Order on Review, as modified by our June 1, 1994 Order on Reconsideration. Specifically, SAIF requests reconsideration of that portion of our order which set aside its denial of claimant's current condition, with the exception of a C5-6 herniated disc.

On June 30, 1994, we withdrew our prior orders for reconsideration. Responses to SAIF's motion have been received from Liberty Northwest Insurance Corporation and claimant. Accordingly, we proceed with our reconsideration.

In our prior order, we found that claimant's accidental injury at Liberty combined with the preexisting condition for which SAIF was responsible. Relying on ORS 656.005(7)(a)(B) and SAIF v. Drews, 318 Or 1 (1993), we concluded that the 1990 injury with Liberty was not the major contributing cause of claimant's current need for treatment and disability and held that responsibility did not shift from SAIF to Liberty Northwest. Thus, claimant had not sustained a new compensable injury at Liberty's insured.

Relying on Bonni J. Mead, 46 Van Natta 775, on recon 46 Van Natta 1185 (1994), which issued subsequent to our order on reconsideration in the present case, SAIF contends that claimant's 1990 injury when Liberty was on the risk combined with the effects of the 1981 injury accepted by SAIF, and, because Liberty accepted a "low back strain," Liberty remains responsible for claimant's combined low back condition, pursuant to ORS 656.308(1). We agree with SAIF's argument.

In Mead, the claimant sustained a compensable injury to her low back while working for AIAC's insured. Approximately one year later, the claimant again injured her low back while employed by Liberty Northwest's insured. Liberty accepted the claim for "temporary exacerbation of chronic lumbosacral strain." On the same date, Liberty partially denied claimant's current chronic lumbosacral strain condition. AIAC denied responsibility.

We concluded, first, that by accepting claimant's claim for a back injury, Liberty conceded that the condition was compensable, i.e., that a new compensable injury had occurred. Second, we concluded that the second injury at Liberty's insured involved the same condition as the 1991 AIAC injury. We said:

> "Although Liberty accepted a 'temporary exacerbation of chronic lumbosacral strain,' the medical record indicates that claimant's 1992 injury, like her 1991 injury, involved a lumbosacral strain. Under such circumstances, we conclude that claimant suffered a new compensable injury at Liberty's insured which involves the same condition that AIAC had previously accepted. Inasmuch as that same condition was the low back condition which is presently under dispute, Liberty remains responsible for that condition."

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

Thus, our first inquiry in the present case is whether a new compensable injury involving the same condition occurred. We conclude that it did.

In our May 6, 1994 Order on Review, we found that claimant's chronic pain syndrome, which included headaches, neck pain, and back and leg spasms, was a compensable consequence of the 1981 SAIF injury. Although Liberty accepted a low back strain/soft tissue injury in 1990, the medical record indicates that claimant experienced acute pain in his right leg, low back, shoulders and neck immediately after being knocked to the ground by a pallet of cartons. Moreover, he continued to experience tension headaches and leg giveway that resulted in falls from the muscle spasms. (Exs. 81 and 91). Drs. Brooks and Keist, who examined claimant for Liberty, opined that, although the major contributing cause for claimant's current need for treatment was his 1981 injury, claimant may have experienced transient worsening of his symptoms due to the soft tissue injuries (Ex. 137-8), and Dr. Holmes, who evaluated claimant for pain center treatment, stated that claimant's 1990 injury was significant, with claimant demonstrating objective impairment attributable directly to the 1990 injury. (Ex. 103-2). In other words, claimant's low back/soft tissue injury when Liberty was on the risk, and which Liberty accepted, involved claimant's chronic pain syndrome, the same condition that resulted from the 1981 injury.

Moreover, by accepting claimant's claim for a low back/soft tissue injury, Liberty conceded that the condition was compensable, i.e., that a new compensable injury had occurred. See Smurfit Newsprint v. Derosset, 118 Or App 368, 372 (1993) (Carrier's acceptance was a concession that claim was compensable). Thus, as the insurer responsible for the most recent accepted claim for claimant's low back condition, Liberty is also responsible for future compensable medical services and disability for the compensable condition. See ORS 656.308; Smurfit Newsprint v. Derosset, supra at 371.[1]

Accordingly, our May 6, 1994 Order on Review, as modified on June 1, 1994, is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior orders in their entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Although no party argued that Liberty's denial was an invalid preclosure denial, a carrier may not issue a partial denial of a previously accepted inseparable condition while the claim remains open. United Airlines, Inc. v. Brown, 127 Or App 253 (1994); Sheridan v. Johnson Creek Market, 127 Or App 259 (1994).

In the Matter of the Compensation of
JAMES V. JOHNSTON, Claimant
WCB Case No. 92-16193
ORDER ON RECONSIDERATION (REMANDING)
Susan D. Isaacs, Claimant Attorney
Lundeen, et al., Defense Attorneys
Wood, Tatum, et al., Defense Attorneys

On June 23, 1994, we abated our June 20, 1994 Order on Review that vacated a Referee's order which had dismissed claimant's hearing request seeking penalties under ORS 656.262(10) or attorney fees under ORS 656.386(1) regarding a medical service dispute which had resulted in a Director's order under ORS 656.327(2) finding a disputed medical service to be appropriate. Reasoning that claimant's request for a carrier-paid attorney fee award under ORS 656.386(1) constituted a "question concerning a claim," we concluded that such a question, when combined with claimant's request for penalties, vested the Hearings Division with jurisdiction to address the issues.

On our own motion, we withdrew our June 20, 1994 order to further consider the question of whether claimant's request for an attorney fee award under ORS 656.386(1) constitutes a matter concerning a claim when the services on which the requested award were based arose from a medical service dispute that was resolved pursuant to a Director's order under ORS 656.327(2). See ORS 656.704(3). In addition, we asked the parties to submit supplemental briefs addressing this question. Both parties' supplemental briefs have been received. After further considering the matter, we issue the following order.

In Marycarol Molin, 46 Van Natta 1782 (1994), we concluded that the Hearings Division (and the Board) have jurisdiction to determine the issue of whether a claimant is entitled to an attorney fee award under ORS 656.386(1) regarding a claimant's contention that her counsel was instrumental in obtaining compensation without a hearing by prevailing as a result of a proceeding before the Director under ORS 656.327. Reasoning that ORS 656.388(1) requires the Board to approve a claim for legal services, we concluded that this grant of approval includes the authority to determine whether the claimant's counsel is entitled to an attorney fee under ORS 656.386(1). Molin, supra.

Here, claimant is seeking an attorney fee award under ORS 656.386(1) for services related to a proceeding before the Director under ORS 656.327. As in Molin, claimant is requesting an attorney fee award under ORS 656.386(1) for his counsel's efforts in obtaining compensation without a hearing. In other words, by seeking an attorney fee before the Hearings Division, claimant has submitted a claim for legal services. Thus, we have jurisdiction to consider the issue raised by such a request. Since that attorney fee issue has also been included with claimant's request for a penalty assessment under ORS 656.262(10), it likewise follows that exclusive jurisdiction over the penalty issue does not rest with the Director.

Accordingly, on reconsideration, we continue to conclude that this matter should be remanded to the Presiding Referee for further action consistent with our June 20, 1994 order. Consequently, as supplemented herein, we republish our June 20, 1994 order, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JACQUALYN M. MARVIN, Claimant
WCB Case No. 93-13581
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

The insurer requests review of that portion of Referee Schultz's order which found that claimant's left wrist claim should be reclassified as disabling. On review, the issue is claim classification. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact. We do not adopt the Referee's fourth Ultimate Finding of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, because claimant had established that she was entitled to an award of permanent disability under the standards, she had proven that her claim was improperly classified as nondisabling. We disagree.

ORS 656.277 provides that claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

> "(1) If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the director for determination pursuant to ORS 656.268."

Additionally, OAR 436-30-045(5) provides:

"(5) A claim is disabling if any of the following conditions apply:

"(a) Temporary disability is due and payable;

"(b) If the worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726;

"(c) The worker is not medically stationary, but there is a substantial likelihood that the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726 when the worker does become medically stationary...."

Here, the Referee found, and we agree, that the only relevant section of the rule is OAR 436-30-045(5)(b). Accordingly, we must determine whether claimant is entitled to an award of permanent disability under the standards.

In Barbara Addington, 46 Van Natta 1474 (1994), we concluded that a statement from the claimant's treating doctor was insufficient to establish that the claimant would be entitled to a permanent disability award under the standards. OAR 436-30-045(5). In Addington, the claimant's doctor had reported that the claimant's physical problem would be present for a long time. The claimant's doctor also explained that restrictions had been recommended because the claimant's chronic strain caused a waxing and waning of symptoms.

In Addington, we held that the doctor's statements regarding the length of time the claimant would have problems did not establish that the claimant's condition was permanent, or that she suffered impairment. Relying on David A. Kamp, 46 Van Natta 389 (1994)(diagnoses of chronic neck and shoulder conditions did not establish that the claimant had established a chronic condition impairment), we concluded that the doctor's description of the claimant's condition implied an eventual resolution of her pain complaints. Addington, supra.

Similarly, in the present case, Dr. Winans, claimant's treating doctor, has reported that claimant has no permanent impairment. Dr. Winans' statement regarding an absence of permanent impairment is consistent with the opinions provided by Dr. Button, who examined claimant for the insurer, and with the opinion of the medical arbiter, Dr. Dineen. Moreover, although Dr. Winans stated that claimant would continue to have symptoms in her wrists, he further provided that she would not have "complete resolution as long as she is doing the type of work at present which is actively using both wrists repetitively." As in Addington, we find that Dr. Winans' statement is insufficient to establish that claimant's condition is permanent. Rather, Dr. Winans' statement implies an eventual resolution of claimant's complaints. Furthermore, Dr. Winans released claimant to regular work, without limitations.

Finally, we conclude that, even if Dr. Winans' latest statement could be construed as a recommendation that claimant avoid repetitive work, we have previously held that such a recommendation, when made to prevent an increase in symptoms, is insufficient to establish a permanent and chronic impairment. Addington, supra; Rae L. Holzapfel, 45 Van Natta 1748 (1993).

Under the circumstances, we conclude that the medical evidence fails to establish that claimant's February 6, 1993 injury has resulted in permanent impairment. Thus, we conclude that, under the standards, claimant will not be entitled to a permanent disability award. Claimant, therefore, is not entitled to reclassification of her claim. Accordingly, claimant's claim shall remain classified as "nondisabling."

ORDER

The Referee's order dated February 17, 1994, is reversed in part and affirmed in part. That portion of the Referee's order that set aside the Order on Reconsideration and remanded the claim to the insurer for acceptance as disabling is reversed, and the Order on Reconsideration is reinstated and affirmed. The Referee's award of an out-of-compensation attorney fee is also reversed. The remainder of the order is affirmed.

Board Member Gunn dissenting.

I am now not convinced that Addington, supra, was correctly decided. When a claimant has a physical problem, due to the injury, that is expected to continue and impairs her ability to perform her job, the doctor's opinion should be construed to mean that claimant has a permanent condition. Here, claimant's doctor has explained that her pain will continue for as long as she continues to perform her job for the employer. Therefore, because claimant is in her late twenties and there is no indication that she intends to retire soon, claimant is expected to continue working for approximately 40 more years with her present impairment. To require that claimant prove more "permanency" to her condition than the remainder of her employable years does not make sense. In a case in which a claimant has such a condition, she should be found to be entitled to an award under the standards and her claim should be classified as disabling. See OAR 436-35-005(5); 436-30-045(5).

Finally, even under the principles expressed in Addington, I would still find that claimant's claim in this case should be reclassified as disabling. In Addington, the treating physician stated that the claimant's problem would be "present for a long time." Consequently, the Board interpreted the doctor's statement as meaning that the complaints would eventually resolve. In the present case however, claimant's treating doctor has stated that claimant's condition will not improve as long as she continues to perform her job. Because Dr. Winan's statement implies that claimant's condition will not resolve for the remainder of her working years, I would find that claimant has a permanent condition and is entitled to an award under the standards. Therefore, I dissent from the majority's decision that this claimant's claim should not be reclassified.

In the Matter of the Compensation of
LOIS J. SCHOCH, Claimant
WCB Case No. 93-09584
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband, Haynes and Gunn.

The insurer requests review of that portion of Referee Podnar's order that awarded $10,500 assessed attorney fees under ORS 656.382 and ORS 656.386. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

On July 16, 1992, the Director issued an order finding the surgery proposed by Dr. Berkeley on February 14, 1993 was inappropriate. On December 10, 1992, Referee Holtan affirmed the Director's order. On remand from the Board, based on the insurer's statement that it was not contesting Referee Podnar's January 10, 1994 order concerning the surgery issue, Referee Holtan held that the case before him had been rendered moot. See Lois J. Schoch, 46 Van Natta 157 (1994).

CONCLUSIONS OF LAW AND OPINION

The hearing lasted approximately three hours. The issues were the reasonableness and necessity of surgery, and penalties and attorney fees for alleged unreasonable denials. Seventy-six exhibits were admitted into the record, including a one hour deposition of the treating surgeon. Claimant and Dr. Rosenbaum, as an expert witness, testified.

Referee Podnar found that, although the insurer's alleged "back-up" denial and denial of claimant's current need for treatment were withdrawn at the time of closing argument, until that time those issues remained viable. Considering the complex medical issues, time and cost factors, and the unreasonableness of the denials, the Referee awarded a $10,500 assessed attorney fee, and indicated that the fee was a combination of fees pursuant to ORS 656.382 and and 656.386.

At hearing, claimant submitted a statement of services seeking a $10,500 attorney fee. Claimant's counsel indicated that he devoted 38.25 hours of time to the case at an hourly rate of $175. On appeal, claimant contends that the fee amount included a reasonable contingent multiplier of 1.5. The insurer contends that the fee awarded by the Referee is excessive, and suggests that a more reasonable fee would be $4,375.

Claimant contends that the fee award includes a reasonable contingent multiplier. However, one of the factors set forth in OAR 438-15-010(4) considers a contingency factor and, thus, do not provide for a separate contingency "multiplier" in determining a reasonable attorney fee for services at hearing. See Wattenbarger v. Boise Cascade Corp., 301 Or 12 (1986); Barbara A. Lewis, 38 Van Natta 1329, 1331 (1986). Therefore, without considering a separate, additional contingency multiplier, and after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee, under ORS 656.386(1), for claimant's attorney's services at hearing concerning the surgery issue is $5,750. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

On the issue of entitlement to a fee under ORS 656.382(1) for the insurer's July 12, 1993 unreasonable denial and its unreasonable "de facto" denial of surgery, the Referee did not assign a separate value for an assessed attorney fee under ORS 656.382(1).[1] Accordingly, we modify the Referee's order.

Here, the insurer's denials had the effect of delaying benefits under the compensable claim. Therefore, the insurer unreasonably resisted the payment of compensation warranting an attorney fee pursuant to ORS 656.382(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee is $2,000 for the insurer's unreasonable denials.

ORDER

The Referee's order dated January 10, 1994 is modified. In lieu of the Referee's $10,500 attorney fee award, claimant is entitled to a $5,750 assessed attorney fee award, under ORS 656.386(1), and a $2,000 assessed attorney fee award, under ORS 656.382(1).

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[1] Apparently, the Referee assessed part of the fee under ORS 656.382(1) on the ground that the insurer's failure to timely accept or deny Dr. Berkeley's May 25, 1993 request for surgery constituted unreasonable resistance to the payment of compensation. We agree. The insurer provided no explanation for its failure to timely accept or deny claimant's surgery request.

The insurer does not contest the Referee's finding that its denials were unreasonable. Assuming, without deciding, the unreasonableness of the denials, a penalty and penalty-related fee pursuant to ORS 656.262(10), nevertheless, cannot be authorized. Since the proposed surgery has not yet been performed, there are no amounts "then due" upon which to base a penalty,. However, an attorney fee under ORS 656.382(1) does not depend on "amounts then due." Such a fee may be assessed for an unreasonable resistance to the payment of compensation. See Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989).

Board Member Gunn dissenting.

I suspect that, because my colleagues in the majority are skilled attorneys who have provided excellent representation and I am only a poor non-attorney who has benefited from such representation, we have a disagreement. But because I not only disagree with my colleagues in this case, but also with the Board's increased dabbling in attorney fee disputes I must dissent.

Attorney fee disputes are best characterized as subjective journeys into a black hole. The present case is a prime example. In this case, the majority admits that although the factors that we apply to determine attorney fees include a "contingency factor," they just will not apply a multiplier. The court case cited by the majority actually states, "[t]he statute [ORS 656.388] does not support a general 'multiplier' for the statistical risk." Wattenbarger v. Boise Cascade Corp. 301 Or 12, 16 (1986). The statute cited by the Court has been modified since this decision. In fact, this case was when fee disputes where appealed to circuit court and when the Board rules did not consider a contingency factor.

The Court in Wattenbarger stated that a "suggested schedule" implied that some degree of judgment was expected in determining what constitutes a reasonable attorney fee. Wattenbarger, 301 Or at 15. Since the Wattenbarger case, the statute has been amended to delete the term "suggested" from the phrase "suggested schedule of fees." This change in conjunction with the Board's subsequent adoption of a "risk factor" in OAR 438-15-010(4)(g) now requires the referees and the Board to consider a contingency factor unrelated to the other factors listed in OAR 438-15-010(4)(g). Therefore, although I do not now suggest that the statute has been modified to include such a multiplier, the Board has adopted by rule the consideration of risk that claimant's counsel will go uncompensated.

What is the the best way to apply a contingency factor? If not prohibited by statute why is a multiplier not a valid consideration under our rule? I see two options for calculating a contingency factor. One would be the use of a multiplier, the other would be to allow high hourly rates. However, in the workers' compensation system where claimants' attorneys are not allowed to charge their clients, but rather payment for services is contingent upon success of the particular case, calculating a reasonable hourly rate would be speculative. In addition, the Board's rule allows for a risk factor, not for a higher hourly rate. Thus, the most effective method for applying the risk factor is the multiplier.

My question is if the majority does not like the multiplier, what would (or did) they apply to the instant case to compensate the attorney for the risk and the high probability that claimant's attorney would go uncompensated? It would appear nothing. This was a difficult case made contentious by the unreasonable conduct of the insurer. Yet, it would appear from the amount given that the majority has adopted the arguments of this same unreasonable insurer in determining the amount to award claimant's counsel. And little if anything was applied to compensate claimant's counsel for the risk that he might go unrewarded for his efforts.

This Board for the last two years has generally avoided these attorney fee disputes by affirming the amounts awarded by the referee absent consideration of the factors in OAR 438-15-010(4), or absent some showing of abuse of discretion by the referee in determining the attorney fee. This has two positive effects. One, it discourages the parties from appealing such disputes thus, reducing litigation. Two, it stops the Board from substituting our subjective judgment for that of the referees subjective judgment. The referees at least have the advantage of observing the parties in action. So, as we generally defer to referees on demeanor credibility findings, we should defer to the referees who have the advantage of actually seeing the work performed for which attorneys get compensated. At worse, attorneys will get less than they deserve and on occasion get more than they deserve. But, at least, we will leave the question of appropiate compensation to the arena where the record is made. The most critical factor at all levels of litigation.

In the instant case, I would find that the cases cited by the majority do not prohibit the consideration of a multiplier factor, and that the majority has failed to apply any consideration for a contingency factor. In general, I would find that, absent consideration of the factors in OAR 438-15-010(4) or an abuse of discretion, the Board should not disturb the fees awarded by a referee, and that the increase in attorney fee disputes is in direct proportion to the recent cases by this Board modifying those fee awards. I would also point out that when employers/insurers appeal attorney fees they accomplish a fee reduction because claimant counsels are required to expend time and money to defend the fee for which this Board will not compensate them. For these reasons, I must respectfully dissent.

In the Matter of the Compensation of
KRISTY R. SCHULTZ, Claimant
WCB Case No. C4-02163
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, Wilson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Member Gunn and Haynes.

On August 23, 1994, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

The proposed agreement provides:

> "The employer/insurer shall agree to waive its right to collect its overpayment in the amount of $12,685.30. In consideration for this payment, the claimant shall release all present and future rights . . ."

Here, the total consideration for the agreement is the carrier's waiver of an "overpayment" of permanent partial disability benefits. Although not entirely clear from the proposed agreement, a portion of these benefits may have been paid pending the carrier's appeal of an award which was subsequently eliminated. But See ORS 656.313(2); Melvin L. Nelson, 46 Van Natta 1676 (1994). No additional sums are to be paid to claimant or claimant's attorney.

We have previously held that, where an overpayment apparently has been made pursuant to prior claims processing obligations, that overpayment cannot logically qualify as "proceeds" of the parties' CDA. See Timothy W. Moore, 44 Van Natta 2060 (1992); Raymond E. Clonkey, 43 Van Natta 1778 (1991).

Furthermore, a carrier may only recoup an overpayment from a future award, if any, of permanent disability, which makes any recovery speculative as it is dependent upon a condition subsequent. For this reason, we have concluded that a carrier's contractual forebearance of its right to pursue an offset cannot serve as consideration for claimant's release of certain rights. Timothy W. Moore, supra.

Accordingly, consistent with the rationale expressed in Moore, supra, and because the proposed agreement provides for no other consideration for claimant's release of his workers' compensation benefits, we find that the CDA is unreasonable as a matter of law. Consequently, we decline to approve it.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

IT IS SO ORDERED.

In the Matter of the Compensation of
BRENDA S. SHARAFI, Claimant
WCB Case No. 93-04777
ORDER ON REVIEW
Dobbins, et al., Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Peterson's order that set aside its denial of claimant's injury claim for a head contusion. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant became involved in an argument with a co-worker, Mr. Smith, concerning a sandwich. The argument involved a heated verbal exchange. There is some dispute as to whether claimant threw her own sandwich at the co-worker, or merely threw her sandwich in the waste can beside the co-worker's desk. However, the parties agree that claimant proceeded to take a portion of Mr. Smith's sandwich and walk away with it. Mr. Smith pursued claimant in an attempt to retrieve his sandwich. The parties disagree as to whether Mr. Smith actually caused claimant to fall or if she simply lost her footing on the slick cement floor. In any event, claimant fell and struck her head.

SAIF argues that claimant's head injury is not compensable because she sustained the injury while actively participating in an assault. See ORS 656.005(7)(b)(A). We disagree.

After a de novo review of the record, we conclude that the sandwich incident between claimant and Mr. Smith never rose to the level of an assault or combat as contemplated by ORS 656.005(7)(b)(A). Rather, the preponderance of evidence indicates that the dispute concerning claimant's sandwich order was primarily a heated verbal exchange that culminated in claimant's decision to take Mr. Smith's sandwich.

The testimony of another co-worker, Mr. Pahlke, indicates that Mr. Smith followed claimant and was simply reaching for his sandwich when claimant fell. (Tr. 69). Moreover, according to Mr. Pahlke, that area of the concrete floor where claimant lost her footing is notoriously slippery. (Id. at 70). Thus, we conclude that claimant's subsequent head injury was caused by accidentally slipping while holding Mr. Smith's sandwich, not by combat between her and Mr. Smith. In other words, while claimant and Mr. Smith were clearly at odds with one another, their mutually antagonistic behavior was not an assault or combat.[1] See ORS 656.005(7)(b)(A).

Finding that no assault or combat transpired, the "aggressor defense" is not applicable to bar claimant's injury claim for a head contusion. See generally, SAIF v. Barajas, 107 Or App 73, on remand Ismeal M. Barajas, 43 Van Natta 1774 (1991). Accordingly, we adopt and affirm the Referee's ultimate finding that claimant's injury claim for a head contusion is compensable. ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 2, 1994 is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, payable by the SAIF Corporation.

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[1] Even claimant describes the physical contact as a "tap" on her back.

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 93-08427
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee Menashe's order that: (1) concluded that the insurer had a legal basis for terminating claimant's temporary total disability after June 20, 1993; and (2) declined to assess a penalty for the termination of those benefits as of that date. The insurer cross-requests review of those portions of the Referee's order that: (1) concluded that the insurer improperly terminated claimant's temporary total disability compensation after June 4, 1993; and (2) assessed a penalty for the allegedly unreasonable termination of those benefits after that date. On review, the issues are unilateral termination of temporary total disability compensation and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings subject to the following exceptions. In lieu of the Referee's finding that, on June 15, 1993, the employer sent claimant a letter notifying him that light duty was available, we find that the June 15, 1993 written work offer was for regular work based upon the employer's testimony that an offer was sent in response to the employer's receipt of a regular work release. (Tr. 36, 37). In lieu of the Referee's finding that claimant testified he never got a letter from the employer with a job offer, we find that claimant never got a letter from the employer with an offer of modified work.

We make the following additional findings. Dr. Sedgwick was claimant's attending physician at the time the insurer terminated claimant's temporary total disability benefits. The insurer did not have a reasonable basis for concluding that its June 15, 1993 written work offer was for modified work.

CONCLUSIONS OF LAW AND OPINION

Unilateral Termination of TTD After June 4, 1993/Related Penalty

On review, the insurer challenges the Referee's ruling that it acted improperly in terminating claimant's temporary total disability (TTD) benefits after June 4, 1993. The insurer also challenges the Referee's assessment of a penalty for its termination of TTD benefits after that date.

We adopt and affirm the Referee's rulings on these two issues, subject to the following comment on the TTD issue.

The insurer argues that the Referee erred in concluding that its termination of benefits after June 4, 1993 was not authorized under ORS 656.268(3)(b). That provision allows an insurer to unilaterally terminate TTD payments when "[t]he attending physician gives the worker a written release to return to regular employment."

Here, the insurer argues that the requirements of ORS 656.268(3)(b) were satisfied by: (1) forms signed by claimant that contain Dr. Barnhouse's written release to regular work as of June 7, 1993; and (2) Dr. Barnhouse's oral communication of this work release to claimant on June 3, 1993. (Ex. 7 and 8; Tr. 17, 47).

The requirements of ORS 656.268(3)(b) are clear, unambiguous and specific in what is required before an insurer may unilaterally terminate TTD benefits. Those requirements were not met here. There is no evidence that claimant saw the forms in question after they were completed by Dr. Barnhouse. Consequently, the written work release in the forms was not given to claimant as expressly required by ORS 656.268(3)(b). Similarly, the verbal work release from Dr. Barnhouse does not satisfy the express statutory requirement that the attending physician give the worker a written release to regular work.

Moreover, the record does not support the insurer's contention that Dr. Barnhouse was claimant's attending physician. Claimant was examined by Dr. Barnhouse on one occasion on June 3, 1993. (Ex. 7-3). Up to that time, claimant had treated exclusively with Dr. Sedgwick. (Ex. 1A, 3). Claimant testified that he self-referred to Dr. Barnhouse to obtain a second opinion. (Tr. 8). The record contains no form noticing a change of the attending physician from Dr. Sedgwick to Dr. Barnhouse. On this record, we are persuaded that Dr. Sedgwick was claimant's attending physician when the insurer terminated TTD payments.

Accordingly, we conclude that the attending physician did not give claimant a written release to regular work within the meaning of ORS 656.268(3)(b). Cf. Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986)(employer must strictly comply with administrative rule setting forth procedural requirements for terminating TTD). Furthermore, we reject the insurer's position that a different conclusion is mandated by the Board's decision in Warren D. Battle, 45 Van Natta 1169 (1993).

In Battle, the Board concluded that ORS 656.268(3) did not authorize the insurer to terminate TTD because, among other things, the attending physician had not given claimant a written release to regular or modified work. In discussing the basis for that decision, the Board stated the following: "* * * claimant is not required to assume that he was to return to work after two weeks without either seeing or being read the written release. That release could have been relayed by a reliable third party, but there is no evidence that the employer[,] * * * in fact, read [claimant] the alleged complete attending physician's release [.]" The insurer argues that this language supports its argument that Dr. Barnhouse's verbal communication of his written release to regular work satisfied the requirements of ORS 656.268(3)(b).

We are persuaded that the aforementioned discussion in Battle is not controlling in the present case. First, this discussion assumes a hypothetical situation rather than the actual facts before the Board in Battle. The issue of whether a written work release can be verbally conveyed to a claimant was not squarely before the Board. In such circumstances, the view expressed by the Board is not generally binding as legal precedent.

Moreover, the facts of the current case are clearly distinguishable from the hypothetical posed in Battle. That hypothetical assumed that the claimant was read a written work release from the attending physician. Here, the written release to regular work was from Dr. Barnhouse, who was not the attending physician.

Accordingly, we reject the insurer's argument that Dr. Barnhouse's written and oral work releases satisfied the requirements of ORS 656.268(3)(b).

We also reject the insurer's argument that, assuming Dr. Sedgwick was the attending physician, his May 20, 1993 chart note was a written release to regular work within the meaning of ORS 656.268(3)(b). In that chart note, Dr. Sedgwick opined that claimant "should be ready to return to full duty" when he returned for a follow-up appointment on June 4, 1993. The insurer argues that this chart note is a written release to regular work which became effective when claimant failed to return for his follow-up appointment. However, there is no evidence that claimant was given a copy of this chart note. Moreover, the chart note does nothing more than speculate as to claimant's future condition. Accordingly, Dr. Sedgwick's statement was not a written release to regular work given to claimant within the meaning of ORS 656.268(3)(b).

Finally, we reject the insurer's argument that it properly terminated claimant's TTD after June 4, 1993 under ORS 656.262(4)(b). The insurer raises this argument for the first time on review. ORS 656.262(4)(b) provides as follows:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer * * * has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control."

Contrary to the insurer's argument, ORS 656.262(4)(b) does not authorize unilateral termination of TTD benefits. Cameron v. Norco Contract Service, 128 Or App 422 (1994); Sandoval v. Crystal Pine, 118 Or App 640, 643, rev den 317 Or 272 (1993). That provision only permits an insurer to "suspend" the payment of TTD until verification of inability to work is obtained. Id. The only means for an insurer to unilaterally terminate TTD is pursuant to ORS 656.268. Id. Accordingly, the insurer did not properly terminate claimant's benefits under ORS 656.262(4)(b).

Moreover, to the extent the insurer "suspended" rather than terminated claimant's benefits, it did not follow the mandatory suspension procedures set forth at OAR 436-60-020(4). In particular, the insurer did not provide prior notice to claimant explaining that his temporary disability would be terminated unless the insurer received written authorization of further temporary disability from an attending physician. OAR 436-60-020(4)(a).

Accordingly, subject to the above comment, we adopt and affirm the Referee's decision that the insurer improperly terminated claimant's TTD benefits after June 4, 1993.

Unilateral Termination of TTD After June 20, 1993/Related Penalty

Claimant challenges the Referee's conclusion that, pursuant to ORS 656.268(3)(c), the insurer had authority to terminate TTD benefits after June 20, 1993. Claimant also contends that the Referee erred in not assessing a penalty for the insurer's unreasonable termination of benefits after that date.

ORS 656.268(3)(c) allows the insurer to terminate TTD benefits where "[t]he attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment." Here, the Referee concluded that the insurer was authorized to terminate TTD benefits after June 20, 1993 based, in part, on a finding that the employer made claimant a written offer of modified employment dated June 15, 1993. On review, claimant contends that the employer's written work offer was for regular rather than modified employment.

The record does not contain a copy of a written offer of modified employment. The record does contain a June 11, 1993 letter to claimant notifying him that the insurer was requesting reinstatement or reemployment with the employer in response to Dr. Barnhouse's release to regular work. (Ex. 11). The testimony of the employer representative indicates that the employer's written work offer was given in response to Dr. Barnhouse's release to regular work. (Tr. 36-38). Finally, claimant testified that he received a written offer of regular work, but not of modified work. (Tr. 47-48). On this record, we find that the employer's June 15, 1993 work offer was for regular rather than modified work. Consequently, the requirements of ORS 656.268(3)(c) were not met.

Furthermore, the insurer has not established that it had a reasonable basis for terminating claimant's TTD benefits after June 20, 1993. In particular, the insurer has not established that it reasonably believed that its June 15, 1993 written offer of employment was for modified work.

Accordingly, we reverse the Referee's ruling that the insurer was authorized to terminate claimant's TTD benefits after June 20, 1993. We further conclude that claimant is entitled to a 25 percent penalty for the insurer's unreasonable termination of TTD benefits after that date. Claimant's attorney shall receive one-half of this penalty in lieu of an attorney fee. ORS 656.262(10)(a).

Claimant is not entitled to an attorney fee for prevailing against the insurer's challenge to the penalty assessed by the Referee. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). However, claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review regarding claimant's entitlement to TTD benefits for the period June 5, 1993 through June 20, 1993. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning this TTD issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's reply/cross-respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 4, 1993 is affirmed in part and reversed in part. In addition to the Referee's award of temporary total disability compensation, claimant is awarded such compensation from June 20, 1993 until properly terminated according to law. Claimant's attorney shall receive 25 percent of this increased compensation, payable directly to claimant's attorney, provided that the total out-of-compensation fees approved by the Referee and the Board orders shall not exceed $3,800. The insurer shall pay a penalty equal to 25 percent of the additional temporary total disability compensation due under this order. The insurer shall pay one-half of this penalty directly to claimant's attorney in lieu of an attorney fee. The remainder of the Referee's order is affirmed. The insurer shall pay claimant a $500 assessed fee for services on review regarding claimant's entitlement to temporary total disability benefits for the period June 5, 1993 through June 20, 1993.

In the Matter of the Compensation of
EDWIN L. SPURGEON, Claimant
WCB Case No. 93-06487
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Lipton's order which upheld the self-insured employer's denial of his right shoulder injury claim. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation.

Claimant has a longstanding right shoulder condition for which he first sought treatment in 1989. In July 1992, he sustained a right biceps tendon rupture when he lifted a board at home. An ultrasound of the right shoulder also revealed a two centimeter degenerative tear of the right rotator cuff. Claimant's longtime attending physician, Dr. Switlyk, an orthopedic surgeon, offered claimant surgery, which claimant refused because his symptoms subsided. Claimant did not seek medical treatment from August 1992 through January 1993. However, claimant testified that he was occasionally symptomatic during this period. Claimant continued to work without serious difficulty.

On January 26, 1993, while working, claimant reinjured his right shoulder pulling a pin on a dolly. On February 11, 1993, claimant returned to Dr. Switlyk, who performed a right rotator cuff repair in April 1993.

Claimant challenges the Referee's conclusion that he failed to prove that the need for treatment of his right shoulder is compensable under ORS 656.005(7)(a)(B). Although agreeing with the Referee that ORS 656.005(7)(a)(B) applies, claimant asserts that he carried his burden of proof with medical evidence from his attending physician that the January 1993 work incident was the major contributing cause of his disability and need for treatment, citing U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). We disagree with claimant.

In Burtis, the claimant had a cervical strain superimposed on a preexisting asymptomatic degenerative cervical spine disease. While the medical evidence indicated that claimant's cervical strain had not caused or worsened the degenerative condition itself, it did establish that the cervical strain had rendered the degenerative condition symptomatic, resulting in a need for surgery. The court concluded that this was sufficient to make the claimant's surgery compensable, inasmuch as the medical evidence established that the cervical strain was the major contributing cause of the claimant's need for surgery. 120 Or App at 358.

We have had occasion to recently apply Burtis in Henry A. Terry, 46 Van Natta 1466 (1994) and Orville L. Lyons, 46 Van Natta 1509 (1994). In both Terry and Lyons, we found medical treatment compensable when compensable injuries had rendered preexisting degenerative spinal conditions symptomatic and where the medical evidence clearly established that work injuries were the major contributing cause of each claimants' need for medical treatment.

We find Burtis, Lyons and Terry distinguishable. Unlike the claimant in Burtis, claimant here had a symptomatic preexisting condition, although the January 1993 incident increased claimant's symptoms from his preexisting degenerative shoulder condition. Moreover, unlike Burtis, surgery had been previously recommended in this case for claimant's symptomatic preexisting condition. Unlike Lyons and Terry, the medical evidence in this case does not establish that the work injury is the major contributing cause of claimant's need for medical treatment. See ORS 656.005(7)(a)(B).

Claimant contends that Dr. Switlyk's medical opinion supports compensability in this case. Claimant's contention notwithstanding, we do not agree. Although his medical opinion can be interpreted differently, we find that, in general, Dr. Switlyk's opinion supports the Referee's conclusion regarding the compensability issue.

Dr. Switlyk opined that, although the major cause of claimant's need for surgery at the time it was performed was the worsening of the underlying rotator cuff pathology due to the January 1993 work incident, the major pathological reason for claimant's surgery was his preexisting, underlying rotator cuff tear. (Ex. 47). Dr. Switlyk explained that, in the absence of claimant's preexisting degenerative rotator cuff tear, the January 1993 work incident by itself would likely not have caused the degree of claimant's right shoulder symptoms. (Ex. 47). We note that Dr. Switlyk had previously indicated that the preexisting rotator cuff tear was the more important factor in claimant's need for surgery, even though surgery was necessary because of increased symptoms resulting from the January 1993 incident. (Ex. 33A).

Therefore, although Dr. Switlyk's medical opinion is not a model of clarity, it supports our finding that the major contributing cause of claimant's need for surgery is the preexisting right shoulder condition, rather than the January 1993 work incident. Our conclusion is further buttressed by the medical opinions of Drs. Neufeld and Fuller, who examined claimant on behalf of the employer.

Dr. Neufeld opined that the major contributing cause of claimant's condition was the preexisting degenerative rotator cuff condition. (Ex. 37). He explained that claimant had a substantial rotator cuff tear prior to the January 1993 work incident and that it was impossible to state that the incident made the tear any larger. According to Dr. Neufeld, Dr. Switlyk's surgery was primarily related to the previously torn rotator cuff. In a thorough medical report and in his detailed deposition, Dr. Fuller opined that indications for shoulder surgery were present prior to the January 1993 incident and that the preexisting degenerative right shoulder condition was the major contributing cause of claimant's need for right shoulder surgery. (Exs. 46, 47A-14, 32).

Since they are thorough and well-reasoned, the medical opinions of Drs. Fuller and Neufeld are persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Under ORS 656.005(7)(a)(B), when a work-related injury combines with a preexisting, noncompensable condition to cause disability or a need for treatment, the worker must show that the injury is the major contributing cause of the disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409, on recon 120 Or App 590 (1993). Based on Dr. Switlyk's opinion, as well as Dr. Neufeld's and Dr. Fuller's, we find that claimant has not met his burden of proof under ORS 656.005(7)(a)(B). Consequently, we agree with the Referee that the employer's denial was proper.

ORDER

The Referee's order dated December 23, 1993 is affirmed.

Board Member Gunn dissenting.

The majority concludes that the medical evidence in this case does not establish that the January 26, 1993 work incident is the major contributing cause of claimant's need for medical treatment for his right shoulder condition. Because I believe that U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), and its progeny are controlling in this case, and because Dr. Switlyk's medical opinion actually supports a finding of compensability, I must respectfully dissent.

In Burtis, the claimant's injury rendered a preexisting degenerative condition symptomatic, resulting in a need for surgery. The court found that a symptomatic worsening of a preexisting degenerative condition which resulted in a need for surgery was sufficient to render the medical treatment compensable. Unlike the majority, I find the facts of this case sufficiently similar to Burtis such that claimant's surgery ought to be compensable.

While claimant here was not entirely asymptomatic prior to the January 26, 1993 work incident, this incident greatly increased symptoms from his preexisting shoulder condition. While the majority attempts to distinguish Burtis by saying that surgery in this case had been previously recommended, this is a distinction without a difference. The fact remains that surgery was not required prior to the January 1993 incident; it was required afterwards. To me, that is a strong indication that the January 1993 incident was the major factor in claimant's need for surgery.

Moreover, as was the case in Henry A. Terry, 46 Van Natta 1466 (1994) and Orville L. Lyons, 46 Van Natta 1509 (1994), I would find that claimant has satisfied his burden of proving medical causation. Although the majority interprets the medical opinion of the attending physician, Dr. Switlyk, as supporting the employer's position, I believe that his opinion as whole supports the claimant.

Dr. Switlyk correctly understood that claimant's preexisting right shoulder condition was substantially quiescent prior to the January 1993 incident, except for some occasional pain with work activities. Claimant was able to work without significant difficulty. Dr. Switlyk, based on this history, clearly opined that the major cause of claimant's need for surgery at the time it was performed was the worsening of the underlying rotator cuff pathology due to the January 1993 incident. (Ex. 47). Dr. Switlyk even characterized the January 1993 incident as a "major aggravation" of his underlying condition. Dr. Switlyk had previously confirmed that the January 1993 incident worsened claimant's underlying condition in correspondence with the employer's claims examiner. (Ex. 31).

Even though Dr. Switlyk did opine that the major "pathological" reason for claimant's surgery was the preexisting, underlying rotator-cuff tear, the medical evidence from Dr. Switlyk more strongly supports the conclusion that the January 26, 1993 work incident was the major contributing cause of claimant's need for medical treatment. Because Dr. Switlyk is the attending physician, we should defer to his medical opinion which supports compensability in this case. Weiland v. SAIF, 64 Or App 810 (1983).

For these reasons, I believe that the majority errs in its interpretation of the medical evidence, and, hence, errs in finding that claimant has failed to sustain his burden of proof. Thus, I must accordingly dissent from the majority opinion.

September 8, 1994 Cite as 46 Van Natta 1826 (1994)

In the Matter of the Compensation of
TERRY D. WAIBEL, Claimant
WCB Case No. 94-02704
ORDER OF DISMISSAL
Angelo Gomez, Claimant Attorney
James Booth (Saif), Defense Attorney

The SAIF Corporation requested review of Referee Herman's order that: (1) directed SAIF to pay temporary disability from January 19, 1993 until such benefits could be lawfully terminated; and (2) assessed penalties for allegedly unreasonable claim processing. The parties have submitted a proposed "Stipulation and Order for Disputed Claim Settlement," which is designed to resolve this dispute, in lieu of the Referee's order.

Specifically, in return for $11,256 ($6,372 of which is a penalty), claimant withdraws his request for hearing. In response to claimant's concession, SAIF withdraws its request for Board review. The parties further stipulate that this matter "shall be dismissed with prejudice and that payment shall be accepted in full settlement of all issues raised or raisable."

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of the Referee's order. In granting this approval, we note that the parties' settlement does not include provisions which list the proposed reimbursement to medical service providers and whether that reimbursement complies with the formula set forth in ORS 656.313(4). In other words, the proposed agreement does not comply with the requirements for proposed disputed claim settlements under OAR 438-09-010(2)(g). Nevertheless, since the parties are actually resolving disputes pertaining to an accepted claim (temporary disability, penalties, and "out-of-compensation" attorney fees), they are not resolving a "dispute over the compensability of a claim." See ORS 656.289(4). Consequently, the parties have partially mischaracterized their agreement as a "Disputed Claim Settlement."

Inasmuch as the stipulation is not a disputed claim settlement, the aforementioned statutory and administrative requirements are not applicable. Furthermore, because the proposed attorney fee payable from the stipulation proceeds ($1,125.60 from $11,256) can be allocated in a manner that does not exceed the statutory and administrative maximums for such awards (TTD - 25 percent of increased TTD, not to exceed $1,050; Penalty - Up to 50 percent of penalty), the agreement is not in violation of the Board's rules.

Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
KIM D. WOOD, Claimant
WCB Case Nos. 92-16294 & 92-11017
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Frank Susak, Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband, Hall, and Haynes.

Claimant requests review of those portions of Referee Tenenbaum's order that: (1) upheld Grocers Insurance's (Grocers') denials of claimant's aggravation claim for a left knee condition; (2) declined to assess a penalty and related attorney fees for Grocers' allegedly unreasonable denial; (3) declined to award an assessed attorney fee for prevailing against Grocers' alleged "de facto" denial of claimant's left patellar conditions; (4) declined to award interim (temporary total disability) compensation from June 1, 1992 to August 18, 1992; (5) declined to assess a penalty and related attorney fee for Grocers' allegedly unreasonable refusal to pay interim compensation; and (6) declined to assess a penalty and related attorney fee for Consolidated Freightways' allegedly unreasonable claim processing. Grocers cross-requests review of that portion of the Referee's order that: (1) awarded claimant interim compensation from May 21, 1992 through May 31, 1992; and (2) assessed a penalty for its allegedly unreasonable refusal to pay the interim compensation. On review, the issues are scope of acceptance, aggravation, interim compensation and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the second paragraph on page 5 of the order.

CONCLUSIONS OF LAW AND OPINION

Scope of Acceptance/Aggravation

Claimant asserts that the Referee erred in upholding Grocers' denials of her aggravation claim for a left knee condition. Before we address that issue, we must ascertain the scope of Grocers' acceptance of claimant's 1989 knee injury claim. Claimant argues that Grocers accepted her entire left knee condition as it existed in 1989, including conditions that were caused by a noncompensable 1988 knee injury and that preexisted the 1989 accepted knee injury. We agree.

We summarize the relevant facts. In 1988, claimant sought treatment for noncompensable left knee pain. Dr. Tesar performed arthroscopic knee surgery in May 1988, and found a chondral defect of the medial femoral condyle and a loose body in the knee. He shaved the condyle and removed the loose body. (Ex. 2-3).

In July 1989, claimant compensably injured her left knee when she slipped and fell while working for Grocers' insured. She sought treatment with Dr. Keizer and filed a claim with Grocers. On August 28, 1989, Grocers issued a written notice of acceptance, which stated that the accepted condition was "left knee strain." (Ex. 9). At the time of claim acceptance, claimant had not made a claim for left knee strain, and no doctor had diagnosed knee strain.

On September 8, 1989, Dr. Keizer performed arthroscopic left knee surgery, which revealed both a dime-sized defect in the central portion of the patella and a chondromalacia defect of the medial femoral condyle. Dr. Keizer shaved the chondromalacia defect. (Exs. 6-5, 10). Claimant continued to complain of knee pain after surgery. On October 5, 1989, Dr. Keizer performed further knee surgery, which revealed a maltracking syndrome with patellar chondromalacia and suprapatellar bursitis. Keizer performed a lateral patellar retinacular release and excised the prepaterallar bursa. (Ex. 12). Grocers paid all medical treatment expenses and temporary disability benefits.

The claim was closed by notice of closure on January 30, 1990, with no permanent disability award. (Ex. 19). By Determination Order dated March 21, 1990, claimant was awarded 5 percent scheduled permanent disability for the left leg (knee). (Ex. 25). By Stipulation and Order dated June 4, 1990, the award was increased to 15 percent scheduled permanent disability for the left knee. (Ex. 36). The stipulated award has become final.

In December 1990, claimant started working at Consolidated Freightways as a filing clerk. In February 1992, she had increased retropatellar and peripatellar discomfort. In June 1992, Dr. Grossenbacher performed arthroscopic surgery with patellar medial facet and medial femoral condyle shaving. (Ex. 40). Thereafter, Grocers denied compensability of and responsibility for claimant's aggravation claim on the ground that claimant's current disability and need for treatment was due to a preexisting condition or that her 1989 work injury was no longer the major contributing cause of her current disability and need for treatment. (Ex. 52). Grocers subsequently denied responsibility for the claim. (Ex. 62).

Consolidated Freightways also denied responsibility for claimant's current left knee conditions. (Ex. 64). At hearing, Consolidated Freightways orally denied compensability of the conditions. (Tr. 8).

It is undisputed that Grocers accepted claimant's 1989 knee injury claim. The dispute concerns the scope of the acceptance. Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). In determining the applicable limits of a "back up" denial, the Supreme Court has held that acceptance of a claim encompasses only those conditions specifically and officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49, 55-56 (1987). In Johnson, the insurer had accepted in writing fewer than all of the claimant's conditions. The court concluded that, because the insurer had taken no action regarding one of the claimant's conditions, the insurer had not accepted that condition. Id. at 56.

In the present case, Grocers' notice of acceptance identified a condition that not only did not exist, the condition was never even diagnosed, and claimant never sought treatment for it. On that ground, Johnson is distinguishable.

Unless we were to treat Grocers' notice of acceptance as a nullity (which we decline to do), we must conclude that Grocers intended to, and did, in fact, accept something. To hold otherwise would leave this claimant, some five years after the original "accepted" injury, with no claim at all. To accept the dissent's application of Johnson would result in the nullification of the entire original claim. The question is, then, what did Grocers accept?

While we recognize that the mere payment of compensation is not acceptance of a condition, ORS 656.262(9), here, we are left with the task, as trier of fact, of searching for evidence of what Grocers did or did not accept. Under these circumstances, we conclude that Grocers' actions, including the payment of compensation for particular conditions, are at least some indicia of what it intended to accept.

Since no "strain" was ever claimed or even diagnosed, it would make no sense for the Board to conclude that Grocers accepted a "strain" condition. Instead, consistent with its payment of all of claimant's medical expenses, we find that, by its notice, Grocers accepted all of the conditions that caused claimant's symptoms and need for treatment following her 1989 compensable left knee injury. See Janet L. Lundsten, 46 Van Natta 1747 (1994); see also Georgia-Pacific v. Piwowar, 305 Or 494 (1988).

Following her work-related fall in 1989, claimant was diagnosed with a left knee medial femoral condyle defect (Exs. 6-4, -5, -7-8); medial femoral condyle osteochondritis dissecans-type lesions (id. at 7, -8); chondromalacia (id. at 2, 5); patellar derangement and malalignment (id. at 2, -8); a dime-sized

patellar defect (id. at 5) and patellar-femoral joint syndrome. (Id.) Because all of those conditions led to claimant's need for treatment following her 1989 work accident, in view of our finding that Grocers intended to accept all of claimant's left knee conditions in existence at the time, we conclude that Grocers accepted all the aforementioned conditions in August 1989, including claimant's preexisting medial femoral condyle condition.

Having ascertained the scope of Grocers' acceptance, we must now address the merits of its aggravation denials. To establish a compensable aggravation, claimant must show a worsened condition resulting from the compensable condition. Perry v. SAIF, 307 Or 654 (1989). An aggravation has two components: causation and worsening. We must first determine whether claimant's condition is compensable. If it is compensable, then we determine whether the compensable condition has worsened. Bertha M. Gray, 44 Van Natta 810 (1992), aff'd Gray v. SAIF, 121 Or App 217 (1993).

There is no contention that claimant's current left knee condition is a secondary consequence of her 1989 work injury. See ORS 656.005(7)(a)(A). Furthermore, in light of our conclusions regarding the scope of Grocers' acceptance, we find no persuasive evidence that her current left knee condition was the result of an unaccepted, preexisting condition. See ORS 656.005(7)(a)(B). Therefore, claimant need only establish that her 1989 accepted conditions were a material contributing cause of her current left knee problems. For the following reasons, we conclude that claimant has met that burden of proof.

Dr. Grossenbacher, one of claimant's treating surgeons, initially concluded that claimant's 1992 knee problems were related to her 1989 work injury. (Ex. 38-2). Subsequently, Grossenbacher opined that claimant's current left knee problems stemmed from her 1988 noncompensable injury to the medial femoral condyle. (See Ex. 57). Dr. McNeil, examining physician, concluded that claimant's current left knee problems were directly related to her 1988 medial femoral condyle condition. (Ex. 58).

Thereafter, Dr. Grossenbacher stated that claimant's primary problem related to her degenerative medial femoral condyle condition, which had been first documented in 1988. (Ex. 61). In a final concurrence letter, Grossenbacher agreed that the major contributing cause of claimant's current condition was the degenerative changes in her medial femoral condyle. (Ex. 65).

On this record, we conclude the the preponderance of the medical evidence establishes that claimant's pre-1989 degenerative medial femoral condyle condition was a material, if not the major, contributing cause of claimant's current left knee conditions. Because we have concluded that Grocers accepted the preexisting medial femoral condyle condition, it follows that claimant has satisfied her burden of establishing that at least one of her 1989 accepted conditions was a material contributing cause of her current left knee problems.

For the foregoing reasons, we conclude that claimant has established the causation element of an aggravation claim. We turn to the worsening element.

To prove a compensable aggravation, claimant must prove that her compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Finally, because claimant received a previous permanent disability award for her condition, she must establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

We conclude that claimant has satisfied each of these elements. Claimant experienced increased symptoms in 1992 which required her to seek medical treatment after over a year without need for treatment. (See Ex. 38). Furthermore, the medical evidence establishes that claimant experienced a pathological worsening of her left knee conditions since the last award of compensation, viz., the parties' stipulation, which rendered claimant unable to work. (See Exs. 53, 57, 59, 65). Finally, we conclude that claimant's need for additional surgery in 1992 was more than a waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

For these reasons, then, we conclude that claimant has established a compensable aggravation of her accepted left knee conditions. Accordingly, we reverse the Referee's decision setting aside Grocers' aggravation denial of claimant's current left knee condition.

Penalty and Related Attorney Fee for Grocers' Allegedly Unreasonable Denial

Claimant asserts that she is entitled to a penalty and related attorney fee for Grocers' allegedly unreasonable aggravation denial. In determining if a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of its denial. If the the insurer based its denial on a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988).

On this record, we conclude that Grocers' denials were not unreasonable. Given that we have concluded, under the circumstances of this case, that Grocers accepted conditions that were not specifically mentioned in its 1989 notice of acceptance, and that the bulk of the medical evidence relates claimant's current left knee problems to her pre-1989 medial femoral condyle condition, we find that Grocers had a legitimate doubt regarding its liability for claimant's aggravation claim. Therefore, a penalty and attorney fee may not be assessed on the basis of Grocers' denial of that claim.

Assessed Attorney Fee for Prevailing against Grocers' Alleged "De Facto" Denials of Claimant's Left Patellar Conditions

Next, claimant seeks an assessed attorney fee for prevailing against Grocers' alleged "de facto" denials of her 1989 left patellar conditions. Inasmuch as we have concluded that, under the facts of this case, Grocers accepted those conditions in 1989, it follows that Grocer did not "de facto" deny those conditions. Accordingly, an attorney fee may not be assessed on that basis.

Interim Compensation

Grocers was required to begin the payment of interim (temporary total disability) compensation no later than the 14th day after it received notice or knowledge of claimant's medically-verified inability to work in the form of a medical report that constitutes prima facie evidence of a compensable worsening of claimant's left knee condition. See ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), aff'd Stanley Smith Security v. Pace, 118 Or App 602 (1993).

The Referee awarded claimant interim compensation from May 21, 1992 through May 31, 1992. On review, Grocers argues that claimant only requested interim compensation beginning June 1, 1992, the date of her latest surgery, and that the Referee erred in awarding interim compensation prior to that date. We agree. (Tr. 4-5). Accordingly, we reverse both the Referee's award of interim compensation for that period and her assessment of a penalty based on those amounts.

Grocers received notice of claimant's medically-verified inability to work due to a worsened condition on June 29, 1992, when it received a copy of Dr. Grossenbacher's June 5, 1992 chart note. (Ex. 38-3). Thus, Grocers was required to begin payment of interim compensation within 14 days thereafter. See ORS 656.273(6). Grocers paid interim compensation for the period from June 1, 1992 through July 21, 1992; it did not pay any additional interim compensation through the date of its August 18, 1992 denial.

The record shows that claimant returned to modified work on July 14, 1992. (Ex. 44, 48; Tr. 21). There is no indication that claimant lost any wages subsequent to her return to work. Because claimant's return to modified work is a basis for terminating temporary total disability benefits, see ORS 656.268(3)(a), we conclude that claimant is not entitled to any additional interim compensation. See Stanley Smith Security v. Pace, supra, 118 Or App at 610. Accordingly, claimant's request for a penalty and related attorney fee for failure to pay interim compensation is denied.

Unreasonable Claim Processing -- Consolidated Freightways

Last, claimant contends that Consolidated Freightways should be assessed a penalty and related attorney fee for its allegedly unreasonable processing of claimant's claim. Specifically, claimant alleges that Consolidated Freightways' verbal compensability denial at hearing was unreasonably late and was not in the proper form.

Even assuming that Consolidated Freightways' claim processing violated statutory requirements, because claimant's "new injury" claim with Consolidated Freightways' is not compensable, we do not find that there was an unreasonable resistance to the payment of compensation Accordingly, a penalty or related attorney fee is not warranted. See ORS 656.262(10)(a); 656.382(1).

Claimant is entitled to an assessed attorney fee for prevailing over Grocers' aggravation denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on Board review concerning the aggravation denial is $3,500, to be paid by Grocers. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and claimant's appellant's and reply briefs), the complexity of the issue, the value of the interest involved, and the likelihood that claimant's counsel will go uncompensated.

ORDER

The Referee's order dated May 4, 1993 is reversed in part and affirmed in part. Those portions of the Referee's order that upheld Grocers Insurance's aggravation denials and awarded claimant interim compensation for the period from May 21, 1992 through May 31, 1992, and assessed a penalty based on those amounts are reversed. The denials are set aside and the claim is remanded to Grocers for processing in accordance with law. Claimant's counsel is awarded an assessed attorney fee of $3,500 for prevailing over Grocers Insurance's denial of claimant's aggravation claim, to be paid by Grocers Insurance. The remainder of the order is affirmed.

Board Member Haynes concurring in part and dissenting in part.

I agree with the majority's decision with respect to the penalty and related attorney fees for Grocers Insurance's (Grocers') allegedly unreasonable denial, interim compensation and Consolidated Freightways' unreasonable claim processing. I also agree with the majority's conclusion regarding claimant's entitlement to an assessed fee for prevailing against Grocers' alleged "de facto" denial of claimant's left patellar conditions.[1] For the reasons set forth in my dissent in Janet L. Lundsten, 46 Van Natta 1747 (1994), I disagree with the majority's analysis and conclusions regarding the scope of Grocers' acceptance, and hence, its conclusion that claimant has established a compensable aggravation claim. Accordingly, I dissent from that portion of the majority's decision.

In my dissent in Lundsten, I stated my belief that Johnson v. Spectra Physics, 303 Or 49 (1987) applies to all questions regarding the scope of an acceptance. In Johnson, which concerned whether a carrier had impermissibly issued a "back-up" denial, the Supreme Court held that "an insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). An insurer's failure to respond to aclaim or one aspect of a claim is neither acceptance nor denial." Id. at 55 (emphasis added). The Court did not limit its holding to a "back-up" denial situation. Accordingly, I adhere to my belief that Johnson applies generally to issues concerning the scope of a carrier's acceptance.

In the present case, the majority attempts to distinguish Johnson on the ground that Grocers' notice of acceptance concerned a nonexistent condition. Because Grocers' notice, in effect, failed to respond to claimant's left knee claim, under Johnson, its action was neither an acceptance or a denial. By reaching a contrary conclusion, the majority effectively re-writes law announced by the highest judicial body in this state. Because I conclude that this case is governed by Johnson, I would find that, with respect to the scope of acceptance issue, Grocers' notice of acceptance was legally without effect.

I also disagree with the majority's analysis with respect to ORS 656.262(9). That statute provides that "[m]erely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability[.]" (Emphasis added.) By stating that payment of medical benefits constitutes indicia of what a carrier intended to accept, the majority has effectively rendered the statute

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[1] I disagree with the majority's reasoning regarding claimant's entitlement to an assessed fee for prevailing against Grocers' alleged "de facto" denials of claimant's left patellar conditions. Although I believe that Grocers' silence regarding claimant's claimed left knee conditions in 1989 was, at most, a "de facto" denial, see Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992), for the reasons set forth in this dissent, I would find that the "de facto" denied conditions were not compensable. Accordingly, although I disagree with its reasoning, I agree with the majority that an attorney fee may not be assessed on that basis.

meaningless. In reaching this conclusion, I recognize that the statute is prefaced with the word "merely." However, in this case, there is nothing but the payment of medical services (and a noneffective notice of acceptance) to support the majority's conclusion that Grocers' accepted all of claimant's 1989 left knee conditions. Because I find that this case falls squarely within the purview of ORS 656.262(9), and in view of the fact that this Board is vested with no legislative authority, I am compelled to disagree with the majority's ORS 656.262(9) analysis.

For the foregoing reasons, I disagree with the majority's conclusion that, by virtue of its 1989 written notice of acceptance and its payment of claimant's left knee medical services, Grocers accepted the litany of conditions diagnosed after claimant's 1989 work injury. Rather, under the circumstances, I would conclude that Grocers did not accept any of claimant's left knee conditions in 1989.

The next issue concerns the applicable legal standard for evaluating the compensability of claimant's aggravation claim. The majority concludes that, in light of its conclusion regarding the scope of Grocers' acceptance, there is no persuasive evidence that claimant's current left knee condition was the result of an unaccepted, preexisting condition, such that ORS 656.005(7)(a)(B)'s major contributing cause standard does not apply. Because I disagree with the majority's premise, I also disagree with its conclusion that ORS 656.005(7)(a)(B) does not apply.

As the majority itself acknowledges, the medical evidence establishes that claimant's current left knee problems are related to her preexisting, noncompensable medial femoral condyle condition. (Exs. 57, 58, 61, 65). There is no persuasive evidence that her 1989 work injury is and remains the major contributing cause of her current left knee problems. See ORS 656.005(7)(a)(B). For that reason, I would conclude that claimant has failed to establish the compensability of her current knee conditions. It follows that she has failed to establish a compensable aggravation. See Bertha M. Gray, 44 Van Natta 810 (1992), aff'd Gray v. SAIF, 121 Or App 217 (1993). Because the majority concludes to the contrary, I dissent.

In the Matter of the Compensation of
HARVEY CALLENDAR, Claimant
WCB Case No. 92-15192
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Barber's order that: (1) upheld the self-insured employer's denial of claimant's left shoulder injury claim; and (2) declined to assess penalties and related attorney fees for the employer's allegedly unreasonable denial. On review, the issues are whether claimant is the employer's worker under former ORS 656.046(1), penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation.

Following his right shoulder injury with a prior employer that was insured by the SAIF Corporation, and ensuing surgeries, claimant tended to use his left hand and arm for heavy work. (See Tr. 22).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion," with the exception of the reasoning regarding whether claimant was paid for his work at the employer's training program, and provide the following supplementation.

The issue presented by this case is whether claimant is a worker for the employer (a community college) within the meaning of former ORS 656.046(1) (since amended by Or Laws 1993, ch 18, § 139). That statute provided:

> "All persons registered at a college and participating as unpaid trainees in a work experience program who are subject to the direction of noncollege-employed supervisors, and those trainees participating in college directed vocational education projects, are considered workers for the college subject to ORS 656.001 to ORS 656.794 for purposes of this section. However, trainees who are subject to other provisions of this chapter or are covered by the Federal Employee's Compensation Act shall not be subject to the provisions of this section." (Emphasis added.)[1]

The Referee concluded that, because claimant was, at the time of his present injury, in an authorized training program that was governed by the vocational rehabilitation procedures set forth in ORS 656.340, claimant was subject to other provisions of ORS Chapter 656. Therefore, the Referee concluded that claimant was not a worker under former ORS 656.046(1).

We agree with that portion of the Referee's analysis. As we said in Michael C. Steelman, 46 Van Natta 1852 (1994), former ORS 656.046(1) excluded from the definition of a college worker those unpaid work-experience trainees who are subject to the direction of noncollege-employed supervisors and are "subject to other provisions of [ORS chapter 656]." Therefore, we concluded, when an injured worker is registered at a college in an approved training program (which is governed by ORS 656.340) as an unpaid trainee subject to the direction of a noncollege-employed supervisor, and is injured during the course of the training program, the trainee is not a worker of the college under former ORS 656.046(1). Here, as in Steelman, claimant was an injured worker in an unpaid college-based approved training program and was subject to the direction of noncollege-employed supervisors. Consequently, in accordance with the Steelman holding, we agree with the Referee that claimant was not a worker under former ORS 656.046(1).

Additionally, we note that the record reveals that, because of his earlier right shoulder injury and subsequent surgeries, claimant tended to use his left hand and arm for heavy work. (See Tr. 22). Accordingly, it is arguable that claimant's current left shoulder injury was a consequence of his original right shoulder injury with SAIF's insured. In that case, this matter would be governed by ORS 656.005(7)(a)(A), the consequential condition statute. See Kephart v. Green River Lumber, 118 Or App 76, rev den 317 Or 272 (1993). If claimant is also subject to that provision of ORS Chapter 656, for that additional reason, claimant would not be a worker for the employer under former ORS 656.046(1).

The Referee also reasoned that the temporary total disability compensation that claimant received while he was in the training program constituted payment sufficient to take claimant outside the purview of former ORS 656.046(1). We have grave doubts about the Referee's reasoning. However, in light of our conclusion that claimant is subject to other provisions of ORS Chapter 656 and, therefore, is not a worker of a college under former ORS 656.046(1), we need not, and do not, address that issue.

ORDER

The Referee's order dated June 24, 1993 is affirmed.

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[1] During the 1993 session, the Legislature amended the last sentence of former ORS 656.046(1) to read: "However, trainees who are covered by the Federal Employee's Compensation Act shall not be subject to the provisions of this section." Or Laws 1993, ch 18, § 139. That is, the Legislature deleted from inclusion in the last sentence trainees who "are subject to other provisions of this chapter."

It is arguable that the 1993 Legislature's deletion was merely a non-substantive correction. The legislative history of the 1993 amendment appears to support that argument. See, e.g., Proposed Amendments to House Bill 2476, 1993: Public Hearing Before the House Judiciary Civil Law and Judiciary Administration Subcommittee (statement of Kathleen Beaufait, Legislative Counsel), February 17, 1993, Tape 23, Side A, 255-end; Tape 24, Side A, 000-022. However, because, in our view, a plain reading of ORS 656.046(1), in both its former and amended states, leads to the conclusion that a substantive change was wrought by the 1993 amendment, we do not accept the argument that the 1993 change was merely a housekeeping measure. Furthermore, because the language in question is, on its face, unambiguous, we need not, and do not, resort to legislative history. See PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993).

In the Matter of the Compensation of
SOLEDAD ESPINOZA, Claimant
WCB Case No. 93-06672
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Westerband, Haynes and Hall.

The SAIF Corporation requests review of Referee Peterson's order that: (1) awarded an assessed fee based on a Director's order that set aside its notice of ineligibility for vocational assistance; (2) set aside a "de facto" denial of claimant's cervical strain claim; and (3) set aside a "de facto" denial of claimant's somatoform pain disorder condition. On review, the issues are attorney fees and compensability. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Attorney Fees

In July 1992, claimant slipped and fell at work. SAIF accepted claims for right shoulder strain and thoraco-lumbar strain. On March 15, 1993, SAIF issued a notice of ineligibility for vocational assistance on the ground that claimant had "returned to full-time, modified work with your employer at injury." Through her attorney, claimant requested review by the Director.

In May 1993, the Director issued an order finding that SAIF's ineligibility determination was "premature" because the "claim remains open and permanent physical capacities are unclear." Therefore, the Director "voided" SAIF's notice and ordered it to determine eligibility for vocational assistance when claimant became medically stationary and had returned to suitable permanent work with the employer at injury.

Claimant requested a hearing, asserting that her attorney was entitled to an assessed fee because, through her counsel's efforts, SAIF's notice of ineligibility was voided and set aside. The Referee found that SAIF's notice constituted a "partial denial of the claim because if the claimant had not timely appealed this notice then she may have lost her right to vocational assistance in the future, should she ever need it." Accordingly, pursuant to ORS 656.386(1), the Referee awarded claimant's attorney an assessed fee of $200. Alternatively, the Referee found SAIF's notice to be unreasonable and that claimant's attorney also would be entitled to the $200 carrier-paid fee under ORS 656.382(1).

SAIF contends that claimant is not entitled to a carrier-paid attorney fee award under either ORS 656.386(1) or ORS 656.382(1). We need not address the applicability of ORS 656.386(1) because we conclude that claimant is entitled to an award under ORS 656.382(1). In reaching this conclusion, we rely on our recent decision in Gustavo Cantu-Rodriguez, 46 Van Natta 1801 (1994).

In Cantu-Rodriquez, we held that a carrier-paid attorney fee award under ORS 656.382(1) was available when a carrier unreasonably resisted the payment of compensation by issuing a premature notice of ineligibility of vocational services. In that case, the claimant sought Director review of a carrier's notice that he was ineligible for vocational assistance. The Director set the notice aside as premature, instructing the carrier to redetermine the claimant's eligibility within 30 days of receiving notice of his permanent restrictions. The claimant then sought an attorney fee award under ORS 656.382(1) for the carrier's allegedly unreasonable resistance to the payment of compensation.

We first discussed that an assessed attorney fee under ORS 656.382(1) was available when there was a compensable claim and unreasonable conduct that results in resistance to the payment of compensation. We found that there was a compensable claim and that the carrier's conduct in issuing the premature notice was without legal basis and, therefore, unreasonable. Furthermore, we found that such unreasonable conduct resulted in the resistance of the payment of compensation because the practical effect of the carrier's notice, had it been allowed to stand, would have been to shift the responsibility for obtaining vocational assistance from the carrier to the claimant. We further concluded that "compensation" under ORS 656.382(1) included services for evaluating eligibility for vocational assistance. Therefore, based on this reasoning, we held that the claimant was entitled to an assessed attorney fee under ORS 656.382(1).

Applying that reasoning to this case, we first note that there is no dispute that claimant has a compensable claim. We also find that SAIF's conduct was unreasonable. At hearing, SAIF's vocational coordinator testified that she issued the notice of ineligibility based on information that claimant had returned to full-time modified work with the employer at injury. (Tr. 21-22). We interpret such testimony as indicating that SAIF based its notice on a determination that claimant was able to return to "available and suitable work with the employer."

Eligibility for vocational services is in part based on finding that the worker is not able to return to "available and suitable" employment with the employer. ORS 656.340(6)(a); OAR 436-120-040(3)(b). "Suitable employment" is the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities. ORS 656.340(6)(b)(B)(i); OAR 436-120-005(6)(a). Here, the record shows only that SAIF understood that claimant had returned to full-time modified work. There is no evidence that it had any information regarding whether claimant had the physical capacity, knowledge, skills and ability to perform the work. Consequently, we conclude that it had no basis for determining that claimant had returned to "suitable employment." As such, it acted unreasonably in issuing its notice of ineligibility.

Furthermore, based on the reasoning in Cantu-Rodriguez, we find that such unreasonable conduct resulted in the resistance to compensation. Thus, we conclude that claimant is entitled to an assessed fee under ORS 656.382(1) and we affirm that portion of the Referee's order awarding a $200 assessed fee for SAIF's unreasonable resistance to the payment of compensation by means of its premature notice of ineligibility for vocational assistance.

Cervical Strain

We adopt and affirm that portion of the Referee's order regarding the cervical strain, including the awards of an assessed attorney fee and penalty.

Claimant's attorney is entitled to an assessed fee for services on review regarding the cervical strain compensability issue. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's services on review regarding this issue is $400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Somatoform Pain Disorder

Finally, SAIF challenges the Referee's conclusion that claimant proved the compensability of a somatoform pain disorder.

In December 1992, claimant's treating physician, Dr. Freeman, referred claimant for evaluation by the Northwest Occupational Medicine Center. The panel diagnosed "somatoform pain disorder, related to injury," noting that "[p]ain symptoms and disability substantially exceed physical findings." (Exs. 1AB-1, 1AC-7). Sharon Labs, psychologist who participated on the panel, later concurred with a letter drafted by claimant's attorney stating that "the major contributing cause of the somataform [sic] pain disorder" was the July 1992 injury. (Ex. 10).

In August 1993, Dr. Fuller, orthopedic surgeon, examined claimant at SAIF's request. He also diagnosed "somatoform pain disorder." (Ex. 9-4). Dr. Fuller subsequently explained that "the diagnosis of somatoform pain disorder is an underlying psychological condition which pre-existed and is separate from the slip and fall incident of 7/8/93 [sic]." (Ex. 9B). Dr. Fuller also indicated that the "major cause of this diagnosis is intrinsic within the psyche of the individual who exhibits this type of pain behavior" and was "not related to occupation and is not caused by injury." (Id).

We find that, although Sharon Labs may have more expertise regarding claimant's somatoform pain disorder, her opinion is no more persuasive than that of Dr. Fuller. Ms. Labs indicated only that the condition was "related to the injury" and subsequently concurred with a "check-the-box" opinion that the injury was the major contributing cause without providing any explanation or reasoning supporting such a conclusion. Dr. Fuller, on the other hand, described the condition and explained why it was not related to claimant's injury.

Therefore, at best, we find that the medical evidence is in equipoise. Consequently, we conclude that claimant did not carry her burden of proving the compensability of her somatoform pain disorder. See ORS 656.005(7)(a), 656.005(7)(a)(A), 656.005(7)(a)(B).

The Referee awarded a carrier-paid attorney fee under ORS 656.386(1) of $1,500 for claimant's counsel's services in prevailing over SAIF's "de facto" denials of claimant's somatoform pain disorder and cervical strain conditions. As a result of our conclusion that the somatoform pain disorder is not compensable, it follows that claimant has only prevailed over the "de facto" denial of the cervical strain condition. Consequently, we modify the Referee's attorney fee award.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's services at hearing regarding the cervical strain condition is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated October 4, 1993 is affirmed in part, modified in part, and reversed in part. The SAIF Corporation's "de facto" denial of claimant's somatoform pain disorder condition is reinstated and upheld. The Referee's assessed attorney fee award of $1,500 (for prevailing over the "de facto" denials of claimant's somatoform pain disorder and cervical strain) is reduced to $1,000 (for prevailing only over the "de facto" denial of claimant's cervical strain condition). The Referee's penalty award based on "amounts due" from the somatoform pain disorder is reversed. For services on review regarding the cervical strain condition, claimant's attorney is awarded an assessed fee of $400, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

Board Member Haynes specially concurring.

Under the doctrine of stare decisis, I am obligated to follow the majority's holding in Gustavo Cantu-Rodriquez, 46 Van Natta 1801 (1994). Nevertheless, I direct the parties' attention to the dissenting opinion in Cantu-Rodriquez.

Board Member Hall specially concurring.

Since I agree that claimant is entitled to a carrier-paid attorney fee award under ORS 656.382(1), I join with my fellow members' reliance on the Cantu-Rodriquez holding. However, I write to register my further agreement with the Referee's conclusion that SAIF's conduct constituted a decision denying a claim for compensation, thereby entitling claimant to an attorney fee award under ORS 656.386(1). See Keith D. Kilbourne, 46 Van Natta 1837 (1994) (Member Hall specially concurring).

In the Matter of the Compensation of
ROGER D. JOBE, Claimant
WCB Case Nos. 92-15112 & 92-10152
THIRD ORDER ON RECONSIDERATION
Gary D. Taylor, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Pursuant to our September 8, 1994 Second Order on Reconsideration, we found that Liberty Northwest, rather than the SAIF Corporation, was responsible for claimant's low back / soft tissue condition, including a chronic pain syndrome. Notwithstanding this conclusion, we neglected to set aside Liberty Northwest's denial and remand the claim to Liberty for further processing in accordance with law. Furthermore, our order also failed to reinstate and uphold SAIF's denial. Finally, we did not shift responsibility for the Referee's $2,000 carrier-paid attorney fee award and our $1,500 attorney fee award from SAIF to Liberty.

In order to correct these oversights, we withdraw our September 8, 1994 order. On reconsideration, as supplemented and modified herein, we republish our September 8, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KEITH D. KILBOURNE, Claimant
WCB Case No. 93-04279
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Referee Holtan's order that set aside a Director's order finding claimant ineligible for vocational assistance. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the following supplementation.

Claimant was injured on July 3, 1991, while working as an asbestos abater. At the time of his injury, he was making $17.34 per hour on a government contract job as an "on-call" employee.

Claimant had previously worked in asbestos abatement for approximately three years. During that time, he had been laid off, or did not work, for several quarters. Claimant did not receive unemployment benefits over the last several years.

On January 14, 1993, SAIF notified claimant that he was ineligible for vocational assistance. Claimant appealed the decision to the Department.

A March 31, 1993 Director's order found that a suitable wage for claimant was $4.75 per hour. The order arrived at the wage by dividing claimant's total wages for the prior 52 weeks by 52, and then adjusting the hourly figure upward to the minimum wage.

Claimant appealed the Director's order.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the rule applied by the Director, OAR 436-120-025, did not apply to claimant's case because claimant had not earned any unemployment benefits. Alternatively, the Referee found that the rule should not be given any effect, as it was inconsistent with ORS 656.340(5), which provides that the objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of injury. We agree that the Director erred in applying OAR 436-120-025.

As a preliminary matter, we find that the hearing before the Referee satisfied the procedures required in a contested case, as set forth in the Court's decision in Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993). Accordingly, the Referee was entitled to conduct a hearing, develop a record, find facts and determine whether the Director's order survived review. Colclasure, supra; William J. Sanchez, Jr., 46 Van Natta 371 (1994).

Turning to the merits of the case, we agree with the Referee's conclusion that the rule applied by the Director is not applicable in the present case. However, we base our conclusion on the following reasoning.

The applicable statute, ORS 656.340, provides in pertinent part:

> "(6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment.
>
> "(b) As used in this subsection:
>
> "(A) A "substantial handicap to employment" exists when the worker, because of the injury, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment."

In determining eligibility for vocational assistance, the Department's rule provides that a worker is eligible for vocational assistance when, among other things, as a result of the limitations caused by the injury, the worker has a substantial handicap to employment and requires assistance to overcome that handicap. OAR 436-120-040(3)(c). Furthermore, the Department's rules define a "substantial handicap to employment," for the purposes of determining eligibility for vocational assistance, as meaning that the worker, because of the injury, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in "suitable employment." OAR 436-120-005(10).

In defining "suitable employment" for the worker, the Department's rule, which is similar to the statute, provides in part that:

> "(a) "Suitable employment" means employment of the kind for which the worker has the necessary physical capacities, knowledge, transferable skills and abilities...." See OAR 436-120-005(6)(a); ORS 656.340(6)(b)(B)(i).

In applying the Department's rules, we find that the Department has provided two rules pertaining to "suitable employment." The first rule, OAR 436-120-005(6)(a)(A) provides that:

> "For the purpose of determining eligibility for vocational assistance, suitable employment includes a wage within 20% of the wage currently being paid for employment which is the regular employment for the worker." (Emphasis supplied).

On the other hand, the Department has also promulgated a rule which provides that:

> "For the purpose of providing vocational assistance, the meaning of "suitable employment" also includes the objective that the employment provide a wage as close as possible to the wage currently being paid for the worker's regular employment. This wage may be considered suitable if not within 20% of the previous wage, if the wage is as close as possible to the previous wage. For other than full-time, permanent employment, suitable wage is determined as described in OAR 436-120-025." (Emphasis supplied). OAR 436-120-005(6)(a)(B).

In reviewing the Department's rules, it is clear that the Director has created a distinction between determining eligibility for vocational assistance, which is controlled by OAR 436-120-005(6)(a)(A), and providing vocational assistance, which is controlled by OAR 436-120-005(6)(a)(B). Therefore, we must determine which of the Department's rules controls this case.

We conclude that the present case involves a determination of eligibility. Specifically, SAIF found that claimant was not eligible for vocational assistance, and claimant appealed that decision to the Director. The Director concluded that the sole issue was "whether (claimant) is eligible for vocational assistance." Accordingly, because the present case involves an initial determination of eligibility, rather than a case in which vocational assistance is being provided to claimant, we conclude that the correct rule is OAR 436-120-005(6)(a)(A). OAR 436-120-005(6)(a)(A) refers to "regular employment," which is defined as "employment of the kind the worker held at the time of the injury or the claim for aggravation, whichever gave rise to the eligibility for vocational assistance; or, the worker's customary employment." OAR 436-120-005(6)(b).

Rather than applying OAR 436-120-005(6)(b), the Director applied OAR 436-120-025. This rule expressly pertains to the calculation of a "suitable wage," which is a term solely used under OAR 436-120-005(6)(a)(B) for evaluating suitable employment for the purposes of providing vocational assistance. Inasmuch as this dispute pertains to claimant's eligibility for vocational assistance, we find that the Director violated ORS 656.340 by relying on OAR 436-120-025. The only rule which provides for application of OAR 436-120-025 (the rule pertaining to other than full-time permanent jobs) is OAR 436-120-005(6)(a)(B), which we have above found to apply solely to cases involving the providing of vocational assistance.

Consequently, in applying OAR 436-120-025(1)(b) and analyzing this matter as a "seasonal/temporary" case, we conclude that the Director has violated the statute by relying on the wrong rule to determine claimant's suitable wage. ORS 656.283(2). Instead, we find that claimant's "regular" employment, which is that of an asbestos abater, is to be considered for the purpose of determining suitable employment and vocational eligibility. OAR 436-120-005(6)(a)(A) and (b). Therefore, claimant's base wage from which to calculate a suitable wage is his at-injury wage of $17.34 an hour as an asbestos abater.

Using a base wage of $17.34 an hour to calculate suitable employment, we conclude that claimant would have a substantial handicap to employment. See e.g. Reyna R. Rolban-Duenez, 46 Van Natta 865, 869 (1994)(Present state and federal minimum wage is $4.75 per hour). Therefore, we find that the eligibility prerequisites of ORS 656.340 have been satisfied. See ORS 656.340(6)(a) and (b)(B)(iii); OAR 436-120-005(10).

Even assuming that OAR 436-120-025 is applicable, we would continue to conclude that the Director's order must be modified.

OAR 436-120-005(6)(a)(A) provides that "[f]or other than full time permanent employment, suitable wage is determined as described in OAR 436-120-025." OAR 436-120-025(1)(b) provides:

> "Seasonal and temporary employment. When the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment benefits are collected, the wage is established by including earned wages and unemployment insurance benefits for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at a full-time rate to establish the base wage." (Emphasis supplied).

The Referee reasoned that OAR 436-120-025(1)(b) did not apply because it was undisputed that claimant did not receive unemployment compensation at any time during the 52 weeks preceding his injury. The Referee also found that the rule was not applicable because it called for combining wages and unemployment benefits, but in the present case, there were no unemployment benefits to be combined with claimant's wages.

We conclude that, for the reasons stated by the Referee, the rule applied by the Director is not applicable to claimant's case. See William J. Sanchez, Jr., supra (The claimant worked during the dry seasons and then collected unemployment during the remainder of the year, warranting the application of OAR 436-120-025(1)(b)) (Emphasis supplied). Accordingly, the Department's rule does not apply to claimant as he has not collected unemployment benefits.[1]

Furthermore, OAR 436-120-025(2) permits the Director to prescribe additional standards for establishing a base wage from which the wage described in OAR 436-120-005(6)(a) can be determined. In the present case, however, the Director did not prescribe such an additional standard.

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[1] In Debra J. Corwin, 46 Van Natta 1478 (1994), we found that the Director correctly applied OAR 436-120-025(1)(b) to a situation in which the claimant's customary employment was "seasonal and temporary," but the claimant did not collect unemployment benefits. To the extent that it is inconsistent with our decision in this case, Corwin is disavowed.

Accordingly, we conclude that the "temporary/seasonal" rule does not apply to this case, and the Director has not prescribed an additional standard. Thus, claimant's situation would not qualify as employment "for other than full-time permanent employment." It necessarily follows that claimant's job at injury must be considered as full-time permanent employment. This conclusion is buttressed by the fact that the Department's rules do not provide a definition of "full-time, permanent employment."[2]

In any event, in light of our construction of the aforementioned rules, as well as our review of the record, we conclude that it is reasonable to find that claimant's work, which involved working for the employer 40 hours a week, Monday through Friday, until the government contract for abatement work was completed, falls within the definition of full-time permanent employment. Here, the employer's witness testified that many of the asbestos workers earned from $12,000 to $20,000 per year and a lot of the employees returned for the next project after the current project was completed. The employer's witness testified that many of the current asbestos workers had been with the company for in excess of a year.

Given the fact that claimant was a permanent full-time employee, we hold that the Director erred by applying OAR 436-120-025(1)(b) to calculate claimant's base wage. That is, the factual situation in this case did not warrant the application of OAR 436-120-025(1)(b). Therefore, we conclude that the Director violated ORS 656.340 by relying on OAR 436-120-025(1)(b) to determine claimant's suitable wage. See ORS 656.283(2)(a). Instead, we find claimant's base wage from which to calculate a suitable wage to be claimant's at-injury wage of $17.34 an hour as an asbestos abater.

Consequently, using a base wage of $17.34 an hour to calculate suitable employment, claimant would have a substantial handicap to employment. See e.g. Reyna R. Rolban-Duenez, 46 Van Natta 865, 869 (1994)(Present state and federal minimum wage is $4.75 per hour). Therefore, we find that the eligibility prerequisites of ORS 656.340 have been satisfied. See ORS 656.340(6)(a) and (b)(B)(iii); OAR 436-120-005(6)(a)(A); OAR 436-120-005(10). Accordingly, because the Director's order countermands eligibility, it must be modified. ORS 656.283(2).

Here, the Referee vacated the Director's order and referred the claim to SAIF to again present the matter to the Director for a determination of vocational eligibility. However, the Referee and the Board's authority is limited to modification of the Director's order. ORS 656.283(2); John R. Coyle, 45 Van Natta 325 (1993). Consequently, we modify both the Referee and the Director's orders to direct SAIF to provide claimant the vocational assistance he would have received based on his at-injury wages as an asbestos abater. See Erwin L. Farmen, 45 Van Natta 463 (1993).

Finally, because we have concluded that the Director violated the statute, we do not adopt the Referee's alternative reasoning which held that, if OAR 436-120-025(1)(b) was applicable to claimant's case, it should not be given any effect.

Attorney Fee/Hearing

Inasmuch as claimant requested a hearing and since that request has resulted in increased compensation, accordingly, claimant is entitled to an out-of-compensation fee, payable directly to claimant's attorney by SAIF. ORS 656.386(2); OAR 438-15-005(1). This fee shall be equal to 25 percent of the increased compensation created by the Referee and Board order, not to exceed $1,050. We note that claimant is not entitled to an assessed fee for his counsel's services at hearing. See Simpson v. Skyline Corporation, 108 Or App 721 (1991)(the question of whether a claimant is entitled to vocational assistance concerns only the availability of a certain type of benefits, rather than whether the claimant's condition was caused by his industrial injury).

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[2] We note that the scope of our decision may be relatively narrow, as it appears that the Director has recently proposed new rules. These rules seek to establish an "adjusted weekly wage to determine suitable wage" and, in doing so, provide a definition for "permanent, year-round employment." See proposed OAR 436-120-310(1)(g), (5).

Attorney Fee/Board Review

In addition, because SAIF requested review of this matter and we have found that claimant's compensation should not be disallowed or reduced, claimant is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for services on review is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that no attorney fee is available for that portion of claimant's brief devoted to the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated November 30, 1993 is modified. The Director's order is modified to direct the SAIF Corporation to provide claimant the vocational assistance he would receive based on his at-injury job as an asbestos abater, consistent with this order. Inasmuch as the modification of the Referee's order has resulted in increased compensation, claimant's counsel is awarded 25 percent of that increase not to exceed $2,800, payable directly to the attorney from SAIF. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, also payable by SAIF.

Board Member Hall specially concurring.

I join the majority on the merits of this case and with the majority's conclusion that the Director's order must be modified to provide claimant with vocational assistance. I also agree that claimant is entitled to an assessed attorney fee for services on Board review. I write separately only to address that portion of the majority's decision which awards claimant a fee out of compensation, ORS 656.386(2), for services before the Referee. I would award an assessed attorney fee for services before the Referee pursuant to ORS 656.386(1). Specifically, although I acknowledge that Simpson v. Skyline, 108 Or App 721 (1991), controls the attorney fee issue in this case, I believe that a discussion of the issue and the prior caselaw may bring certain concerns to the attention of the court and the practitioners, in order that such concerns might someday be addressed.

I would first point out that the instant case is factually different from Simpson, in which the claimant prevailed before the Director and only proceeded to a hearing on the issue of attorney fees. Here, SAIF notified claimant he was ineligible for vocational assistance. The Director's order also found that claimant was not entitled to vocational assistance. Claimant then requested a hearing from the Director's decision. The assessed fee, therefore, would be for claimant prevailing before the Referee. See Sherry Y. Drobney, 46 Van Natta 964 (1994).

Irrespective of any factual differences in the cases, I believe that the dispositive issue, in whether an assessed attorney fee is available pursuant to ORS 656.386(1), should be whether there has been a denial of a claim for "compensation." In Simpson, the court cited Short v. SAIF, 305 Or 541 (1988), for the proposition that no assessed fee is available for a case in which the issue is the "availability of a certain type of benefit, rather than whether claimant's condition was caused by his industrial injury..." Simpson, supra. I construe the court's order to mean that, under Short v. SAIF and in the context of ORS 656.386(1), a denied claim for compensation can only be defined as a denial of "compensability" (i.e., medical or legal causation of the injury or disease itself). However, I respectfully suggest that we examine the original foundation underlying Short v. SAIF.

The Court's decision in Short pertained to circuit court review of attorney fees (i.e., whether such court review was available). In Short, claimant sought review in the Court of Appeals concerning the date of claim reopening and the amount of attorney fees (i.e., the amount of benefits and fees). The Court of Appeals adjusted the date of claim reopening and upheld the award of fees. Claimant then petitioned the Circuit Court to increase the attorney fees. The case then proceeded to the Court of Appeals and the Supreme Court on the issue of Circuit Court review of attorney fees. (See Short, 305 Or at 543, 544). In reaching its conclusion on Circuit Court review of fees, the Court stated:

> " * * * ORS 656.386(1) provides for attorney fees on review of denied claims. The claimant did not appeal to the board or to the Court of Appeals from a decision denying her claim. Both the referee and the board concluded that the claimant's condition was compensable. Where the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute and the ORS 656.388(2) route to the circuit court is not available. Shoulders v. SAIF, 300 Or 606, 615, 716 P2d 751 (1986). See also Vandehey v. Pumilite Glass and Building Co., 35 Or App 187, 580 P2d 1068 (1978) (ORS 656.386 not applicable because employer conceded causation, issue was extent of treatment warranted); Smith v. Amalgamated Sugar Co., 25 Or App 243, 548 P2d 1329 (1976) (extent of disability rather than cause of injury, disputed); Grudle v. SAIF, 4 Or App 326, 479 P2d 250 (1971) (amount of compensation for amputation rather than cause of injury, disputed). Cf. Ohlig v. FMC Marine & Rail Equipment, 291 Or 586, 633 P2d 1279 (1981) (where employer denies compensability of a condition, rather than disputes extent of liability and amount of compensation due, employer has "denied" the claim, distinguishing Vandehey, Smith, and Grudle); Cavins v. SAIF, 272 Or 162, 536 P2d 426 (1975) (same)." Short v. SAIF, 305 Or 541, 545-546 (1988).

The critical distinction is between amounts or extent of compensation due and denial of a claim for compensation. Short, as with its predecessors, should not be construed to require denial of "compensability" of the original or underlying injury or disease. It is enough that a claim for compensation be denied. See ORS 656.386(1); Gwen A. Jackson, 46 Van Natta 357 on recon 46 Van Natta 822 (1994). Claims for vocational services, like medical services, are claims for compensation. See Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992); Billy J. Eubanks, 35 Van Natta 131 (1983). Thus a denial of vocational services or medical services (i.e., a denial that claimant's need for vocational services or medical services is not caused by or the result of the compensable claim) is a denial of a claim for compensation.

There is a second reason why Short, and thus Simpson to the extent it relies upon Short should not be controlling authority in the present case. In the present case, the applicable statute is amended ORS 656.386(1). Unlike the version of ORS 656.386(1) at issue in Short, the amended statute provides in part: " * * * If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed. * * * ". The court's decision in Simpson indicates that the amended statute is being applied, but there is no discussion regarding the difference in the statute. I would respectfully submit that the amended statute goes a step further in not requiring a denial of compensability but only a denial of a claim for compensation.

Finally, I believe that even if the statute had not been amended, ORS 656.386(1) speaks in terms of a denial of the "claim for compensation," rather than a denial of the original or underlying claim of compensability. Accordingly, because a claim for vocational assistance falls within the definition of a claim for compensation, an assessed attorney fee should still be available even though an insurer might not be denying the underlying claim. Under the statute, an insurer's denial of compensation is all that is required.

In this case, then, claimant's claim for vocational services was denied. Claimant prevailed after a hearing before a Referee. Therefore, claimant has met the requirements of ORS 656.386(1), and an assessed attorney fee should be available. Consequently, if it were not for Simpson, I would award an assessed fee under ORS 656.386(1), rather than a fee out of compensation under ORS 656.386(2).

Board Members Haynes and Neidig dissenting.

Because we find that the Director applied the correct rule in this case, which is the rule pertaining to temporary/seasonal employment, we dissent from the majority's decision.

First, we note that the majority relies upon claimant's "wage" of $17.34 per hour to find a substantial handicap to employment, when compared to the minimum wage of $4.75 per hour. However, we find it more reasonable to consider claimant's average monthly salary as an asbestos abater. For example, if claimant earned a typical annual salary of between $12,000 to $20,000, as the

employer's witness testified, yet he was only required to work for six months to earn such a salary, his average wage would be between $1,000 to approximately $1,700 per month for that year. Using a monthly wage in that range would result in a more reasonable "wage" for claimant, which might not fall in the minimum wage category, but would more accurately reflect the fact that claimant did not earn $17.34 per hour for a full year of work.

We also disagree with the majority's statement that claimant fits within the group of workers described as permanent/full-time employees. Although the Department may not have a definition for that term, it is clear to us that this worker, who was basically "on-call" and did not work for several quarters over the past few years, is a seasonal/temporary worker, rather than a permanent full-time employee. The Director's finding in that respect is consistent with the testimony of the employer's witness who stated that the work slowed down in the winter which often required laying off some of the abaters, who either found other work or collected unemployment benefits between jobs.

Finally, we conclude that the wage calculation used by the Board in Corwin, supra, is correct. Neither the claimant in Corwin, nor the claimant in this case, collected unemployment benefits, yet the Director (and the Board in Corwin) found that the rule for temporary/seasonal employees was the correct rule for determining a suitable wage. We find it entirely reasonable that, if workers have unemployment benefits, such benefits may be included in the calculation under the rule, and if they have not chosen to avail themselves of such benefits, the wage is still properly calculated under the rule based on their status as temporary/seasonal workers, which is the main focus of the rule.

In dissenting from the majority's opinion, we find that the intent of the statute, and our policy, should be to provide retraining for workers to enter the workforce at a wage within 20 percent of their current wage. If a worker is permanent/full-time, or is seasonal and is willing to work (or is available to work as is evidenced by the collection of unemployment benefits) between jobs, such workers will be entitled to vocational assistance. If a worker chooses, however, to take time off between jobs or to make himself unavailable for employment, then vocational assistance should not be provided and the worker should reenter the job force at minimum wage.

September 9, 1994 Cite as 46 Van Natta 1843 (1994)

In the Matter of the Compensation of
KENNETH W. MATLACK, Claimant
WCB Case No. 93-10533
ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our August 11, 1994 Order on Review which awarded an attorney fee of 25 percent of increased compensation created by the order, not to exceed $3,800. SAIF states that our order contains a typographical error in that OAR 438-15-040 limits the attorney fee to a maximum of $2,800.

While our order incorrectly cited OAR 438-15-040, which applies to situations in which a Referee awards additional permanent disability, the "Order" section does correctly state the maximum attorney fee in cases where the claimant has appealed the Referee's award of permanent disability and the Board's order increases the claimant's award of permanent disability. See OAR 438-15-055.

Therefore, our August 11, 1994 order is corrected to change the citation on page three of our order from OAR 438-15-040(1) to OAR 438-15-055(1). Accordingly, we withdraw our August 11, 1994 order. On reconsideration, as corrected herein, we adhere to and republish our August 11, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DON V. MYERS, Claimant
WCB Case No. 92-15161
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Westerband, Hall, and Neidig.

Claimant requests review of Referee Livesley's order which upheld the SAIF Corporation's denial of claimant's medical services claim for his current (1992) condition. In addition, claimant moves to remand this case to the Referee for the receipt of additional evidence obtained after the hearing. On review, the issues are remand and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following deletion and supplementation.

We do not adopt the following sentence under the Referee's findings of ultimate fact: "Demerol is not a reasonable treatment for chronic pain."

We add the following findings of fact: "While hospitalized in June 1992, claimant received high doses of IV Demerol in order to manage his chronic neck pain. (Exs. 37-2; 39 at 15-16, 22). Such high doses of IV Demerol were required to relieve claimant's pain because claimant had developed tolerance to pain medications, as a result of long-time treatment for his chronic compensable neck condition. (Exs. 36; 37; 39 at 17, 22, 38)."

We also add the following finding of ultimate fact: "The compensable 1983 neck injury was at least a material contributing cause of claimant's need for the IV Demerol treatment he received while hospitalized in June 1992."

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

Claimant moves to remand this case to the Referee for receipt of two reports by Drs. Watson and Burr, who examined claimant in November 1993 at SAIF's request. Claimant requests remand for consideration of this newly generated evidence which was not available prior to closure of the record on June 28, 1993. SAIF opposes the motion.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem 80 Or App 152 (1986). We consider the proffered evidence only to determine whether remand is appropriate.

Here, the evidence was not available for the Referee's consideration at the June 28, 1993 hearing, because it was generated several months after the record closed. However, we cannot conclude that similar evidence was not obtainable with due diligence at the time of the hearing. Although the reports were not generated until after the hearing record closed, those reports contain no new information regarding the 1992 condition that was not obtainable with due diligence prior to the hearing.

In addition, we do not find that the record is incompletely developed without the additional evidence. Drs. Watson and Burr reviewed and described claimant's condition and treatment up to November 1993, including the 1992 condition. They opined that, to the extent claimant's 1992 condition related to his tolerance of narcotic medications, prescribed for his chronic neck pain stemming from the 1983 injury, his need for treatment in 1992 was related to the compensable 1983 injury. We find that this opinion is merely cumulative of medical opinions already in the record. Both Drs. Jewell and Metcalf, whose reports and deposition testimony are in the record, offered essentially the same opinion. (See Exs. 36, 37; 39 at 22, 39-40).

Under these circumstances, we do not find that the record was "improperly, incompletely or otherwise insufficiently developed." For these reasons, claimant's motion to remand is denied.

Compensability

The Referee held that, in order to establish the compensability of his current (1992) condition, claimant must prove that his compensable 1983 neck injury was the major contributing cause of his consequential acute respiratory distress syndrome (ARDS) condition in 1992. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). The Referee concluded that claimant failed to prove that his 1983 neck injury was the major contributing cause of that condition. We disagree.

First, we briefly summarize the pertinent facts. Claimant sustained a compensable neck injury in 1983, which resulted in chronic neck pain following several cervical surgeries. Over the years, claimant's chronic neck pain was controlled by narcotic pain medications, to which claimant eventually developed a tolerance.

On June 25, 1992, claimant was hospitalized following an off-work injury to his head which caused increased neck pain, among other symptoms. While he was hospitalized, claimant received high doses of intravenous (IV) Demerol, a narcotic pain medication, to manage his chronic neck pain. As a result of the high doses of IV Demerol he received, claimant suffered acute respiratory distress, or ARDS, which required intensive surgical and medical treatment.

Claimant contends that the consequential ARDS condition is compensable because his 1983 neck injury was the major contributing cause of that condition. We agree with claimant, based on the following analysis.

In a recent decision, Kathleen A. Robinson, 46 Van Natta 833, on recon 46 Van Natta 1677 (1994), we reexamined and reaffirmed the appropriateness of the Board's analysis and decision in George Hames, Jr., 45 Van Natta 2426 (1993), with the following clarification of our analysis for determining the compensability of a consequential condition caused by treatment for a compensable injury:

> "[W]hen a consequential condition arises as the result of compensable medical treatment for a compensable injury, the compensable injury is the major contributing cause of the consequential condition if the medical evidence establishes that the compensable treatment was the major contributing cause of the consequential condition. [Citations omitted]. In other words, ORS 656.005(7)(a)(A)'s major contributing cause standard will be satisfied if the claimant establishes that: (1) the medical treatment for a compensable injury was the major cause of a consequential condition; and (2) the medical treatment was materially related to the compensable injury. [Citations omitted]." (Emphasis in original).

The court has recently affirmed our decision in Hames. Barrett Business Services v. Hames, 130 Or App 190 (1994). In Hames, the court disagreed with the carrier's contention that we had erroneously equated consequences of the treatment of a compensable injury with consequences of the compensable injury itself. Specifically, the court held that where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A).

Here, the medical evidence establishes that the major contributing cause of claimant's 1992 ARDS condition was the high dose of IV Demerol he received while hospitalized. (See Exs. 28-3; 30; 36-2; 37-2; 38; 39-17). In addition, there is no contention that the treatment was not reasonable and necessary.

We further find, based on the preponderance of medical evidence, that claimant received the IV Demerol in order to control his chronic neck pain, not for treatment of his head injury. (Exs. 37-2; 39 at 15-16, 22). The very high dose of Demerol was required to control claimant's chronic neck pain because

claimant had developed a tolerance to pain medication due to long-time treatment for his chronic neck pain.[1] (Exs. 36; 37; 39 at 17, 22, 38). Under these circumstances, we conclude that the IV Demerol claimant received while hospitalized in June 1992 was at least materially related to his compensable neck injury. See ORS 656.245(1)(a); Beck v. James River Corp., 124 Or App 484 (1993) (material contributing cause standard applied to medical services claim for treatment for compensable condition necessitated by diagnostic procedure for an unrelated condition).

Consequently, we conclude that claimant has established, by a preponderance of the evidence, that the IV Demerol treatment he received while hospitalized in 1992 was reasonable and necessary treatment related to his compensable 1983 neck injury, and that the Demerol treatment was the major contributing cause of his consequential ARDS condition. Accordingly, consistent with the Hames rationale, we hold that claimant's compensable neck injury itself is properly deemed the major contributing cause of the consequential ARDS condition under ORS 656.005(7)(a)(A).

Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $4,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated July 20, 1993 is reversed. The October 14, 1992 denial is set aside, and the claim is remanded to the SAIF Corporation for processing in accordance with law. Claimant's attorney is awarded $4,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

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[1] The dissent characterizes claimant's drug tolerance as a noncompensable consequence of his compensable neck injury, and as such, considers it to be an "intervening event" which breaks the direct causal relationship between treatment for claimant's compensable injury and the consequential ARDS condition. We disagree. The medical evidence establishes that claimant developed compensable drug tolerance as a direct result of long-term treatment for his chronic neck pain. There is no contention that any other cause contributed to the development of the drug tolerance, nor does SAIF contend that the long-term treatment of claimant's chronic neck pain is not compensable. Under the circumstances of this case, we conclude that drawing a distinction between claimant's compensable chronic neck pain and the drug tolerance he developed over time is artificial. Accordingly, we consider claimant's drug tolerance as much a part of the compensable condition as his chronic neck pain.

Board Chair Neidig dissenting.

I am bound by the court's recent decision in Barrett Business Services v. Hames, 130 Or App 190 (1994). Nevertheless, I adhere to the view that Hames was not correctly decided, as expressed in my special concurrence in Kathleen A. Robinson, on recon 46 Van Natta 1677 (1994). Moreover, I believe the court's analysis in Hames is distinguishable from the facts in this case. Therefore, I respectfully dissent from those portions of the majority's opinion which found claimant's consequential ARDS condition compensable and awarded an attorney fee.

I agree with the majority that the compensability of claimant's 1992 acute respiratory distress syndrome (ARDS) condition is properly analyzed under ORS 656.005(7)(a)(A) as a consequential condition. Under the court's analysis in Hames, when a consequential condition flows "directly and inexorably" from the compensable injury, rather than as the result of a "capricious intervening event," the causal relationship is qualitatively different from the pure "but for" causal relationship in Hicks v. Spectra Physics, 117 Or App 293 (1992), and Kephart v. Green Lumber, 118 Or App 76, rev den 317 Or 272 (1993). Hames, supra, slip op at 4-5. In other words, when a consequential condition is the direct consequence of treatment for a compensable injury, it is compensable under ORS 656.005(7)(a)(A) if the compensable treatment is the major contributing cause of the new injury or condition. Id. at 5-7.

Here, I believe claimant's consequential ARDS condition did not flow "directly and inexorably" from his compensable 1983 neck injury, nor was the 1992 ARDS condition a "direct consequence" of compensable treatment for his compensable neck condition. Therefore, consistent with the court's reasoning in Hames, I conclude that claimant's 1992 ARDS condition is not compensable.

The medical evidence is not in dispute regarding the immediate cause of claimant's ARDS condition in 1992. Claimant's acute respiratory distress was directly caused by the high doses of IV Demerol he received while hospitalized in June 1992. (See Exs. 28-3, 36, 37, 38). Claimant was hospitalized in June 1992 following an off-work fall in which he injured his head and exacerbated his chronic neck pain. The medical evidence also establishes that the high doses of Demerol were administered to control claimant's chronic neck pain, coupled with his drug tolerance. (Exs. 36, 37, 39-17).

Dr. Bravo, the admitting physician and treating physician Dr. Jewell's partner, opined that the major cause of claimant's respiratory failure was the medication prescribed for him as a result of the off-work fall. (Ex. 38).

Consulting orthopedist Dr. Metcalf opined that, while claimant's fall might have triggered a symptomatic exacerbation of his chronic neck pain, the treatment he received was for his chronic neck pain, coupled with his tolerance to pain medications which made his chronic pain difficult to control. (Ex. 37 at 2-3).

Attending physician Dr. Jewell opined that the major cause of claimant's respiratory failure was due to his chronic pain and tolerance to pain medications. (Ex. 39 at 39-40). However, he also opined that ultimately the major cause of claimant's respiratory failure was the off-work fall which caused the medication to be administered at a very high dosage, explaining that "he had never required anywhere near this dosage of medication previously." (Ex. 39-34).

I believe the medical evidence establishes that claimant's off-work fall was a significant intervening event. Indeed, his attending physician considered the fall ultimately the major contributing cause of claimant's respiratory failure. Thus, because of the intervening role of claimant's off-work fall, I believe this case is not governed by the court's decision in Hames.

In addition, the medical evidence identifies claimant's drug tolerance as a significant factor in causing the ARDS condition. Both Dr. Jewell and Dr. Metcalf identify claimant's chronic neck pain, coupled with his drug tolerance, as the major cause of his ARDS condition. While I agree that claimant's compensable injury includes the chronic neck pain condition, I do not agree that the drug tolerance, which claimant developed allegedly as the result of treatment for his chronic neck pain, is also part of claimant's compensable injury. I view claimant's drug tolerance as a consequential condition as well, allegedly caused by treatment for the compensable neck injury. However, the issue of the compensability of claimant's drug tolerance condition is not before us in this case. Claimant sought only to establish the compensability of his consequential ARDS condition. Accordingly, I do not consider claimant's drug tolerance condition to be part of his compensable injury.

I conclude that, under the circumstances of this case, claimant's respiratory failure was not a direct and inexorable consequence of his compensable neck injury. I find that the causation analysis here is complicated by the role of intervening events; specifically, an off-work fall and claimant's noncompensable drug tolerance. Therefore, I believe the majority errs in applying the court's analysis in Hames to the facts in this case.

I believe the correct question under ORS 656.005(7)(a)(A) in this case is whether the compensable cervical strain injury, including chronic neck pain, is the major contributing cause of claimant's consequential ARDS condition. I believe that the preponderance of medical evidence answers that question in the negative.

In summary, I believe this case demonstrates the extremely tenuous relationship that can exist between a compensable injury and a consequential condition under the majority's interpretation of ORS 656.005(7)(a)(A) in the case of treatment-induced consequential conditions. Because the majority has gone astray in its interpretation of ORS 656.005(7)(a)(A), I respectfully dissent from that portion of its opinion which found claimant's ARDS condition to be a compensable consequential condition.

In the Matter of the Compensation of
ALBERT H. OLSON, Claimant
WCB Case Nos. 93-01334 & 93-01119
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall, Westerband, and Neidig.

The self-insured employer requests review of Referee Hoguet's order that: (1) set aside its denial of claimant's psychological condition claim; and (2) affirmed an Order on Reconsideration awarding claimant 5 percent (16 degrees) unscheduled permanent disability. On review, the issues are compensability and extent of permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

In 1974, claimant compensably injured his low back while working for Consolidated Freightways. In 1992, claimant again injured his low back while working for Freightliner Corporation. In a proceeding concerning the 1992 injury, Referee Bethlahmy found that claimant proved compensability and that Freightliner was responsible. The Board affirmed the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm that portion of the Referee's order regarding the compensability of claimant's psychological condition with the following supplementation.

After undergoing surgery in July 1992, claimant reported for work in November 1992. After working a short period one day, claimant was sent home. In December 1992, claimant received a letter from the employer stating that, based on the permanent restrictions imposed by claimant's treating neurosurgeon, Dr. Smith, it was "unable to identify any job that you are capable of performing on a regular full-time basis."

In January 1993, Dr. Avery, who also treated claimant's back condition, referred claimant to Dr. Johnson, psychiatrist, for treatment of depression. The Referee, pursuant to ORS 656.005(7)(a)(A), found that claimant proved the compensability of his condition. The employer challenges this conclusion, asserting that claimant did not carry his burden of showing that the 1992 injury was the major contributing cause of his psychological condition.

We agree with the Referee's application of ORS 656.005(7)(a)(A). The record shows that claimant became depressed when the employer refused, because of claimant's injury-related disability, to allow claimant to return to work in November 1992 and then notified him that no position was available. Claimant's job loss due to his injury-caused disability resulted in the reasonably foreseeable consequence of his loss of self-esteem, as well as feelings of worthlessness and failure. (Exs. 16, 17, 18, 19). Inasmuch as claimant's unemployment was a direct consequence of his injury, we conclude that the compensability of claimant's psychological condition properly is treated as a consequential condition of his compensable injury. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Vador Ruth Kennedy, 45 Van Natta 246, 247 (1993) (compensability of psychological condition caused by compensable injury and its sequelae, including job loss, analyzed under ORS 656.005(7)(a)(A).)[1]

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[1] This conclusion is also consistent with legislative history recited in the court's recent decision in Barrett Business Services v. Hames, 130 Or App 190 (1994). In Hames, the court affirmed our order in George Hames, Jr., 44 Van Natta 2426 (1992), which held that claimant's ulnar nerve condition (which arose from claimant's physical therapy for a compensable shoulder condition) was a compensable consequential condition under ORS 656.005(7)(a)(A). In reaching its conclusion, the court disagreed

Kennedy is instructive. There, the claimant sustained a compensable knee injury, as a result of which she was unable to return to her regular work as a security guard. Claimant became depressed and sought psychological counseling. The medical evidence from claimant's treating psychologist, as well as an examining psychologist, directly related claimant's psychological treatment to her injury and its sequelae, including loss of her job and self-esteem. On the basis of this evidence, we concluded that claimant's compensable injury and its sequelae were the major contributing cause of her need for treatment, and that her psychological condition was compensable. 45 Van Natta at 248. See also SAIF v. Freeman, 130 Or App 81 (1994) (psychological condition remained compensable because the medical evidence established that the claimant became depressed and lost self esteem and confidence when his ability to produce or work was diminished as a result of his compensable injury).

Likewise, in this case, claimant's job loss and related loss of self-esteem are sequelae of claimant's compensable injury. The issue is whether claimant's compensable injury, including injury-related sequelae, are the major contributing cause of his need for psychological treatment. Vador Ruth Kennedy, supra. We agree with the Referee that claimant has carried his burden of proof.

The medical record establishes that claimant's compensable injury and its sequelae, including claimant's inability to continue employment because of injury-related disability, were the major contributing cause of his depression. (Exs. 16, 17, 18, 19). Dr. Johnson, claimant's treating psychiatrist, directly related claimant's depression to the employer's inability to accommodate claimant's injury-related disability, i.e., claimant's job loss. (Ex. 16). Dr. Avery concurred with Dr. Johnson's analysis and emphasized that claimant's mental disorder was related to his injury-related unemployment and loss of self-esteem. (Ex. 17). Finally, Dr. Turco, examining psychiatrist, also directly related claimant's depression to his job loss. (Exs. 18, 19).

Although none of these physicians expressly stated that claimant's compensable injury and related sequelae were the "major contributing cause" of claimant's mental disorder, it is well-settled that medical opinions need not mimic statutory language or use "magic words." See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). It is sufficient that the medical evidence can be reasonably interpreted as establishing major causation. Based on this record, we find that the medical evidence satisfies claimant's burden of proof. Claimant's depression condition is compensable.

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with the carrier's contention that we had erroneously equated consequences of the treatment of a compensable injury with consequences of the compensable injury itself. Specifically, the court held that where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A).

Here, unlike Hames, claimant's consequential depression condition was not "treatment-induced." Therefore, the Hames holding is not directly controlling. Nevertheless, in analyzing the proper application of the statute, the Hames court referred to legislative history which is likewise helpful in our analysis of this case. In discussing ORS 656.005(7)(a)(A), Mr. Jerry Keene, workers' compensation defense attorney stated as follows:

> "This [statute] applies only to what are called natural consequence cases. You trip over your crutches and you break your leg. That's a direct and natural consequence. You develop a depression condition because you're out of work because you have a bad back. That is the main cause of your subsequent depression. But if that depression also develops at the same time you underwent a divorce or your mother died or something, unless the people that you're treating with it's the psychiatrist that say the major contributing cause was the fact you are out of work, that psych condition will not come into the workers' comp system." Tape recording, Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 272. (Emphasis supplied).

As explained in our decision, the medical evidence persuasively establishes that claimant's compensable low back injury and his ensuing job loss as a result of that injury are the major contributing cause of his depression. Consequently, consistent with ORS 656.005(7)(a)(A), as discussed by the court in Hames and interpreted by our decision in Kennedy, we conclude that claimant's depression is a compensable consequential condition. See also SAIF v. Freeman, supra.

The dissent misinterprets our conclusion herein. We are not applying a "but for" test. We have found that claimant's compensable injury is the major contributing cause of his depression. It is not the employer's actions (inability to provide continued employment), but rather the impact of claimant's disabling injury on his mental state (including the emotional response to his physical inability to continue work with this employer), that has caused, to a major degree, his depressed condition.

Extent of Permanent Disability

As a result of the 1974 injury, claimant eventually was awarded a total of 50 percent unscheduled permanent disability. After the 1992 injury, the Determination Order and Order on Reconsideration found that claimant's impairment under the standards was 36 percent. However, both orders deducted 31 percent in consideration of claimant's prior permanent disability award, leaving an award of 5 percent permanent disability. The Referee affirmed the award under ORS 656.222 and OAR 436-35-007(3), which implements ORS 656.222.

The employer asserts that, in view of his prior award of 50 percent permanent disability, claimant is not entitled to any additional permanent disability. We disagree.

We first note that ORS 656.222 is not applicable to this case since it is limited to subsequent awards of scheduled permanent disability. See City of Portland v. Duckett, 104 Or App 318 (1990). However, under ORS 656.214(5), if a claimant suffers from disability due to a preexisting injury and has received unscheduled permanent disability for such disability, the prior disability award is considered in arriving at the appropriate permanent disability award for the current injury. Patrick D. Whitney, 45 Van Natta 1670 (1993). This determination requires a two-step process. First, we determine the current extent of disability under the standards. We then compare this value with the prior award of unscheduled permanent disability to decide if the current award reflects any preexisting disability for which the claimant received benefits. If preexisting disability is included in the current award, the award is reduced by an amount that represents the previously compensated loss of earning capacity. Id.

With regard to claimant's current extent of disability, the parties do not challenge the value of 36 percent permanent disability found by the Determination Order and Order on Reconsideration. After reviewing the record, we conclude that claimant is entitled to a portion of this award.

At the time that claimant was awarded a total of 50 percent permanent disability, claimant worked in the tool room and was permanently restricted from bending, twisting, and lifting more than 25 pounds. (Ex. 10-2). Following the 1992 surgery, claimant's treating neurosurgeon, Dr. Smith, released claimant to work in the tool room, restricting him from bending, stooping, crawling, or lifting more than 25 pounds. (Ex. 17).

Such evidence shows that claimant's work restrictions did not change following his 1992 back surgery. However, prior to the 1992 injury, claimant worked in the tool room. Following the injury, despite having nearly the same work restrictions, the employer informed claimant that his work restrictions prevented him from performing any work for the employer. Under such circumstances, we are persuaded that, despite similar work restrictions, claimant's earning capacity was more limited following the 1992 injury. Furthermore, we agree that 31 percent of claimant's current disability under the standards reflects preexisting disability.

Consequently, we conclude that claimant is entitled to the 5 percent awarded by the Determination Order and Order on Reconsideration.

Attorney Fees on Review

Inasmuch as we have affirmed the Referee's order, claimant is entitled to an attorney fee for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney for claimant's attorney's services on review is $1,700, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the case, and the value of the interest involved.

ORDER

The Referee's order dated May 18, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,700, to be paid by the self-insured employer.

Board Chair Neidig dissenting.

Based on the following reasons, I disagree with the majority's conclusion that claimant's psychological condition is compensable under ORS 656.005(7)(a)(A).

Under ORS 656.005(7)(a)(A), "no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." (Emphasis supplied). The court has construed the statute in three decisions relevant to this case.

First, in Hicks v. Spectra Physics, 117 Or App 293 (1992), the court considered the compensability of a claimant's injury sustained in a motor vehicle accident while returning from treatment for a compensable injury. Based on legislative history, the court held that, under ORS 656.005(7)(a)(A), "any injury or condition that is not directly related to the industrial accident is compensable only if the major contributing cause is the compensable injury." Id. at 297 (emphasis in original).

The court again examined ORS 656.005(7)(a)(A) in the context of an injury sustained while participating in vocational rehabilitation. Kephart v. Green River Lumber, 118 Or App 76 (1993). Because the injury was not directly related to the industrial accident, the court determined that compensability was proved only with evidence that the compensable injury was the major contributing cause. Id. at 79.

The court has most recently construed this provision in Barrett Business Services v. Hames, 130 Or App 190 (1994). In Hames, the court stated "that where necessary and reasonable treatment of a compensable injury is the major contributing cause of a new injury, a distinction between the compensable injury and its treatment is artificial." Id. Therefore, the court held that in such instances the compensable injury itself is deemed the major contributing cause of the new injury for purposes of ORS 656.005(7)(a)(A). Id.

I believe that the Hames decision is not consistent with the clear language of ORS 656.005(7)(a)(A). That is, the court essentially found that the phrase "compensable injury" as it is used in that provision actually means compensable injury or reasonable and necessary medical treatment as a result of the compensable injury. The court conceded that it was employing a "but for" causation analysis, but reasoned that the causal relationship was "qualitatively different" from the facts of Hicks and Kephart because the consequential condition was not the result of some "capricious intervening event," but rather "flowed directly and inexorably from the compensable injury." Hames, supra.

Regardless of my disagreement with the Hames decision, I am constrained to follow the court's directive under the principle of stare decisis. However, I do not believe that Hames controls the resolution of this case and the majority's conclusion is an unwarranted expansion of the Hames decision.

While reasonable and necessary medical treatment (which causes a consequential condition) may flow directly and inexorably from the compensable injury, the causal connection between the inability to work and loss of self esteem and a consequential psychological condition is much more tenuous. The majority has expanded the Hames court's definition of "compensable injury" in ORS 656.005(7)(a)(A) so that it now means compensable injury, or reasonable and necessary medical treatment resulting from the compensable injury, or any feelings of loss the compensable injury might cause.[1]

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[1] The majority also cites SAIF v. Freeman, 130 Or App 81 (1994) as support for its conclusion. In Freeman, SAIF argued that the claimant's psychological condition was caused by a motivation for further workers' compensation benefits. In contrast, the issue here is whether claimant's loss of work and self esteem can be considered as part of the compensable injury for purposes of applying ORS 656.005(7)(a)(A). Moreover, the Freeman court did not reference ORS 656.005(7)(a)(A) and it appears, from the court's use of the word "remains" and the fact that the claimant had a preexisting condition, that the court was actually applying ORS 656.005(7)(a)(B). Consequently, I do not believe Freeman, supra, is applicable.

Although the majority argues to the contrary, essentially it is finding claimant's depression compensable because it would not have occurred "but for" his compensable condition. The medical evidence in this case shows that, following his compensable injury, claimant became depressed due to the employer's decision that claimant's physical limitations rendered him incapable of performing any available work. (Exs. 16, 17, 18, 19). Thus, the compensable injury was not the major contributing cause of his psychological condition. Consequently, I would find that claimant's depression is not compensable under ORS 656.005(7)(a)(A).

In the Matter of the Compensation of
MICHAEL C. STEELMAN, Claimant
WCB Case Nos. 93-00369, 93-00367 & 93-00368
ORDER ON REVIEW
Neil Jackson & Associates, Claimant Attorneys
Bostwick, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Portland Community College (PCC), a self-insured employer, requests review of that portion of Referee Crumme's order that set aside its denial of claimant's chemical injury claim. On review, the issue is whether claimant is PCC's worker under former ORS 656.046(1). We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. The following is a summary of the pertinent facts.

Claimant sustained a compensable injury in September 1988 while employed by a SAIF Corporation insured. As a result of that injury, claimant entered an authorized training program under the auspices of PCC. The training plan included six months of on-site professional skills training, which was provided by Teleco Telephone Co. (Teleco). During the training program, claimant's activities were directed by Teleco, not PCC.

While he was a Teleco trainee, claimant received temporary total disability benefits from SAIF as a result of the 1988 injury with SAIF's insured.

On October 13, 1992, claimant suffered a chemical and septic waste exposure injury to his skin while training with Teleco. PCC denied compensability of and responsibility for that injury on the basis that claimant was not its employee.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was covered by the provisions of former ORS 656.046(1) (since amended by Or Laws 1993, ch 18, § 139) and, therefore, was entitled to compensation from PCC for the injuries that he received while enrolled as an unpaid trainee in a work experience program where he was subject to the direction of a noncollege-employed supervisor. PCC contends that claimant, as an injured worker, is subject to ORS 656.340, as well as all of the other provisions of ORS 656.001 to 656.794, and is, therefore, excluded from the coverage provided to unpaid trainees under former ORS 656.046(1). We agree with PCC.

The issue presented by this case is whether claimant is a worker for PCC within the meaning of former ORS 656.046(1). That statute provided, in pertinent part:

> "All persons registered at a college and participating as unpaid trainees in a work experience program who are subject to the direction of noncollege-employed supervisors * * * are considered workers for the college subject to ORS 656.001 to ORS 656.794 for purposes of this section. However, trainees who are subject to other provisions of this chapter or are covered by the Federal Employee's Compensation Act shall not be subject to the provisions of this section." (Emphasis added.)

The resolution of this issue requires that we interpret former ORS 656.046(1). In doing so, our task is to discern the legislature's intent. ORS 174.020. The best indication of legislative intent is the statutory language itself. Englander v. Thunderbird, 315 Or 633, 638 (1993). Only if the statutory language fails to reveal the legislature's intent do we resort to the context and history of the statute. See PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993).

We conclude that, on its face, former ORS 656.046(1) reveals a legislative intent to provide workers' compensation coverage for persons registered at a college as unpaid work-experience trainees subject to the direction of noncollege-employed supervisors, unless those trainees "are subject to other provisions of [ORS chapter 656]." Because a person in an approved training program is subject to other provisions of ORS chapter 656, particularly ORS 656.340, it follows that unpaid trainees in authorized training programs are per se excluded from former ORS 656.046(1)'s coverage. Therefore, when an injured worker is registered at a college in an approved training program as an unpaid trainee subject to the direction of noncollege-employed supervisors, and sustains another injury while working as such a trainee, the trainee is not a worker of the college under former ORS 656.046(1). Because the statutory language plainly reveals the legislature's intent in enacting former ORS 656.046(1), we do not resort to the context or history of the statute.[1]

Here, claimant initially sustained an injury while working for a SAIF insured. He then became an unpaid trainee in a work experience program under the auspices of PCC, where he was subject to the direction of noncollege-employed supervisors. Because the work experience program was a training program approved pursuant to ORS 656.340, claimant necessarily was subject to other provisions of ORS chapter 656. Because under former ORS 656.046(1), a worker of a college does not include trainees that are subject to other provisions of ORS chapter 656, as explained above, claimant necessarily is excluded from the statute's coverage.[2] For these reasons, we reverse the Referee's decision setting aside PCC's denial of claimant's chemical injury claim.

ORDER

The Referee's order dated May 17, 1993 is affirmed in part and reversed in part. Portland Community College's denial is reinstated and upheld in its entirety. The Referee's attorney fee award is reversed. The remainder of the Referee's order is affirmed.

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[1] PCC argues that amended ORS 656.046(1) is further support for its position that claimant is not its worker under that statute. During the 1993 session, the Legislature amended the last sentence of former ORS 656.046(1) to read: "However, trainees who are covered by the Federal Employee's Compensation Act shall not be subject to the provisions of this section." Or Laws 1993, ch 18, § 139. That is, the legislature deleted from inclusion in the last sentence trainees who "are subject to other provisions of this chapter."

Claimant argues that the 1993 legislature's deletion was merely a non-substantive correction. The legislative history of the 1993 amendment appears to support that argument. See, e.g., Proposed Amendments to House Bill 2476, 1993: Public Hearing Before the House Judiciary Civil Law and Judiciary Administration Subcommittee (statement of Kathleen Beaufait, Legislative Counsel), February 17, 1993, Tape 23, Side A, 255-end; Tape 24, Side A, 000-022. However, because, in our view, a plain reading of ORS 656.046(1), in both its former and amended states, leads to the conclusion that a substantive change was wrought by the 1993 amendment, we do not accept the argument that the 1993 change was merely a housekeeping measure. In any event, because we have concluded that the plain language of former ORS 656.046(1) resolves the issue presented by this case, we need not, and do not, resort to the legislative history of either the former or amended version of the statute.

[2] PCC also contends that claimant's claim fails because: (1) his receipt of temporary disability benefits from SAIF is inconsistent with ORS 656.046(3), which proscribes the payment of temporary disability to an unpaid worker covered by ORS 656.046; (2) claimant's receipt of temporary disability payments are "wages," so that he is not an "unpaid trainee" subject to coverage under former ORS 656.046(1); and (3) it intended to exclude from coverage those students who were covered by their prior employer, based on a prior job injury. In light of our conclusion that claimant's claim falls outside the purview of former ORS 656.046(1) because he is subject to other provisions of ORS chapter 656, we need not, and do not, address those issues.

In the Matter of the Compensation of
JIMMIE JOE GREENE, Deceased, Applicant
WCB Case No. CV-94004
PROPOSED ORDER (CRIME VICTIM ACT) (REMANDING)
Diane Brissenden, Assistant Attorney General

This matter is before the Board on request for a hearing filed by Kwanlea Greene (hereinafter "applicant", on behalf of her deceased husband). Applicant sought review of the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated February 22, 1994. By its order, the Department denied compensation to the applicant under the Compensation of Crime Victim Act (ORS Chapter 147)

A hearing was set for July 11, 1994. At applicant's request, the hearing was postponed and rescheduled for August 15, 1994. Pursuant to notice, the record was opened by Monte Marshall, special hearings officer, on August 15, 1994, in Salem Oregon. The Department of Justice Crime Victims' Compensation Fund ("Department") was represented by Diane Brissenden, Assistant Attorney General. Applicant did not appear at the hearing.

OAR 438-82-040(4) provides:

> "If the applicant fails to appear at the requested hearing, the special hearings officer shall forthwith issue an order requiring the applicant to show cause in writing within ten days why the applicant's request for Board review of the Department's decision should not be dismissed as having been abandoned. If no or insufficient response is received to the order to show cause, the Board may dismiss the applicant's request for review of the Department's decision or may take such other action as it deems appropriate."

Pursuant to this provision, an Order to Show Cause would normally be issued since applicant did not appear at the scheduled hearing. However, at hearing, the Department submitted a copy of the formal police report, including interviews and statements of witnesses to the incident. The police report was not received by the Department until after it had issued its order in this matter.

Inasmuch as these materials were not considered by the Department in reaching its decision, I am presently unable to consider the materials. See ORS 147.155(5); OAR 438-82-040(3). Nevertheless, I am empowered to conduct proceedings in any manner that will achieve substantial justice. ORS 147.155(5).

As described above, the materials submitted by the Department have relevance to applicant's claim for benefits. Since the Department denied applicant's claim for benefits based on its conclusion that it could not determine the degree that the victim's actions contributed to his death, the police investigative report of the incident is highly relevant. Considering the relevance of these materials, I conclude substantial justice would be served by the Department's consideration of these materials. See Kimberly S. Kaelin, 43 Van Natta 2432 (1991). Consequently, this matter should be remanded to the Department for its review of these submitted materials.[1]

In reaching this conclusion, I emphasize that I am in no way passing judgment on the merits of applicant's claim for benefits. Rather, I am merely holding that, in the interests of substantial justice, the aforementioned relevant materials should be considered by the Department before it reaches its decision regarding the applications for benefits.

Inasmuch as I find that remand is appropriate in this matter, it would serve no purpose at this time to require the applicant to show good cause for her failure to attend the hearing. In other words, regardless of whether applicant could or could not establish good cause for her failure to appear at the rescheduled hearing, it would still be appropriate to return this case to the Department for consideration of the police report.

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[1] In reaching this conclusion, I am aware of the Department's representation made at hearing that it is doubtful that the submitted materials will change the outcome of applicant's request for benefits. However, since the submitted materials have not been considered by the Department, I believe that the interests of substantial justice would be better served by the Department's formal consideration of the materials. Following its reconsideration, if the Department continues to adhere to its prior decision, it may issue such an order explaining this reasoning for such a conclusion.

Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Fund for further consideration of this record, consistent with this order. The Department is directed to reconsider this record, including the aforementioned submitted materials. Should applicant continue to disagree with the Department's decision following its reconsideration order, she may re-petition the Board for review of the Department's reconsideration order.

IT IS SO ORDERED.

NOTICE TO ALL PARTIES: This order will be reviewed automatically by the Workers' Compensation Board within 30 days and will become a final order of the Workers' Compensation Board 30 days from the mailing date of this order unless this order is sooner withdrawn or modified by the Board. Objections to this proposed order must be in writing and filed with the Workers' Compensation Board, 2250 McGilchrist Street SE, Salem, OR 97310, within 20 days from the date of this order to be considered.

September 9, 1994 Cite as 46 Van Natta 1855 (1994)

In the Matter of the Compensation of
MERRY E. FRANKLIN, Claimant
WCB Case No. 92-14761
ORDER OF ABATEMENT
Willner & Heiling, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our August 12, 1994 Order on Reconsideration which: (1) directed SAIF to provide vocational assistance to claimant; and (2) awarded claimant's counsel an "out-of-compensation" attorney fee. Contending that we erred in calculating claimant's "base wage" for purposes of determining her eligibility for vocational assistance, SAIF seeks remand for further development of the record. In addition, SAIF requests clarification of our "out-of-compensation" attorney fee award.

In order to further consider this matter, we withdraw our August 12, 1994 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

September 12, 1994 Cite as 46 Van Natta 1855 (1994)

In the Matter of the Compensation of
JAMES E. BOGLE, Claimant
WCB Case No. . 93-04776
ORDER OF ABATEMENT
Pamela A. Schultz, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

The Board has received claimant's motion for abatement and reconsideration of our Order on Review dated August 11, 1994.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The employer is requested to file a response to the motion within 10 days from the date of this order. Thereafter the Board shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOLA M. SPRINGER, Claimant
WCB Case No. 93-07471
ORDER OF ABATEMENT
Gary L. Tyler, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our August 22, 1994 Order on Review that set aside SAIF's denial of claimant's right shoulder, arm and hand condition.

In order to allow sufficient time to consider the motion, we withdraw our August 22, 1994 order. Claimant is granted an opportunity to respond to SAIF's motion. To be considered, that response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUBEN F. VASQUEZ, Claimant
WCB Case No. 93-09363
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Brazeau's order that set aside an Order on Reconsideration, which set aside the Determination Order as premature. In his brief, claimant requests remand to correct the record. The insurer cross-requests review of that portion of the Referee's order that set aside its partial denial of claimant's current left shoulder condition. On review, the issues are remand, compensability, and premature claim closure. We deny the motion to remand and affirm.[1]

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

In his brief, claimant has submitted the second page of Exhibit 11, which was inadvertently omitted from that exhibit. Claimant, thus, requests that the case be remanded to the Referee to completely develop the record. The insurer joins in the request.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5).

Inasmuch as the "exhibit" was admitted at hearing and the missing page has been submitted on Board review (and the parties do not question the authenticity of the reproduced "missing page"), we find that the record has not been incompletely developed. Consequently, we have considered page two of Exhibit 11 in conducting our de novo review. Accordingly, it is unnecessary to remand.

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[1] Member Gunn suspects that the parties might find inconsistent that we find a condition compensable today and medically stationary over three years earlier. I would note that medical treatment provided claimant has been more diagnostic than corrective.

Premature Claim Closure

The Referee found that the medical evidence contemporaneous with claimant's medically stationary date established that no further improvement in claimant's condition was reasonably expected with treatment or the passage of time. The Referee, therefore, concluded that claimant was medically stationary at the time of the January 15, 1993 closure of his claim.

Claimant contends that, because no doctor specifically stated that his condition was medically stationary, it was appropriate for the Referee to consider circumstantial evidence. Claimant, thus, contends that the Referee erred in failing to consider the entire record, including medical reports subsequent to the medically stationary date.

The question of claimant's medically stationary status is primarily a medical question requiring competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981); Austin v. SAIF, 48 Or App 7 (1980). The reasonableness of medical expectations of improvement must be judged as of the date of closure, without considering subsequent changes in claimant's condition. Alvarez v. GAB Business Services, 72 Or App 524, 527 (1985).

On this record, no doctor explicitly stated that claimant was medically stationary on June 14, 1992. Nonetheless, "magic words" are not necessary to establish a medically stationary date and circumstantial evidence is as effective as a direct statement. Jennifer Matthies, 44 Van Natta 39 (1992); see also Austin v. SAIF, 48 Or App 7, 12 (1980). In determining whether claimant is medically stationary, we examine medical evidence available at the time of closure, as well as evidence submitted after closure. However, medical evidence submitted after closure that pertains to changes in claimant's condition subsequent to closure is not considered. Scheuning v. J.R. Simplot Co., 84 Or App 622 (1987).

Dr. Paluska, claimant's then treating physician, last treated claimant on December 13, 1990 when he recommended an independent evaluation for a closing examination. Claimant was incarcerated in the Oregon State Penitentiary in December 1990. Dr. Becker examined claimant on May 2, 1991 for complaints in the left posterior periscapular area. Dr. Becker reported that a shoulder arthrogram and a CT scan were normal. He recommended that if an EMG study was normal, then claimant's condition was medically stationary. Claimant was subsequently transferred to a prison in Texas, where he was examined by Dr. Zeeck on July 8, 1992. Based on a finding of symptom magnification and the lack of objective findings, Dr. Zeeck recommended no additional evaluation and placed no restrictions on claimant. A January 15, 1993 Determination Order closed the claim and found claimant's condition to be medically stationary on June 14, 1992. Claimant was released from prison in February 1993.

On May 3, 1993, claimant sought treatment from Dr. Olson contending that for the last two months his left shoulder had been worse. Dr. Olson believed that claimant had median neuropathy at the carpal tunnel and possibly an ulnar neuropathy at the elbow. An MRI and nerve conduction studies, however, were normal. Dr. Olson, thereafter, recommended physical therapy for a frozen shoulder and biceps tendinitis.

On August 13, 1993, claimant sought treatment from Dr. Irvine for persistent left parascapular and trapezial distribution shoulder pain. Dr. Irvine felt that claimant had pain syndrome of the left neck and upper extremity of uncertain etiology. He recommended an MRI (to rule out cervical disc herniation) and nerve conduction studies (to rule out CRS). Dr. Irvine concluded that if no etiology could be found, then claimant's condition was medically stationary. Considering the previous normal MRI and nerve conduction studies, we find that Dr. Irvine's opinion supports finding claimant medically stationary. In addition, Dr. Irvine did not recommend any new diagnostic tests nor any new treatment that would be expected to improve claimant's condition.

Drs. Snodgrass and Duff examined claimant on September 2, 1993. They found no evidence of a frozen shoulder or nerve dysfunction as suspected by Dr. Olson. They noted marked inconsistencies and symptom magnification. They opined that claimant was very unlikely to improve with any further treatment.

The medical evidence indicates that claimant's left shoulder condition has not materially changed since claim closure, although he has persistent pain complaints. Claimant may experience continuing symptoms, yet his condition can be medically stationary. Maarefi v. SAIF, 69 Or App 527 (1984). Accordingly, we conclude that claimant's condition was medically stationary at the time of claim closure.

Partial Denial

We adopt and affirm the Referee's findings and conclusions concerning this issue.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's cross-request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 19, 1994, as reconsidered on January 27, 1994, is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the insurer.

September 13, 1994 Cite as 46 Van Natta 1858 (1994)

In the Matter of the Compensation of
JAMES H. WATSON, Claimant
WCB Case No. C4-02084
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Emmons, Kropp, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On August 12, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition, and add the following reasoning.

Here, the parties have agreed that a certain sum of money will be paid to claimant, and an attorney fee, commensurate with the Board rules, will be paid to claimant's attorney from that sum.

Additionally, the CDA provides:

> "It is agreed that the permanent partial disability award granted by Notice of Closure dated July 18, 1994 shall continue to be paid to the worker during the time this settlement is before the Board. The claimant retains the right to request a lump sum payment of any remaining balance of the award." (Emphasis added). (P. 3, Ln. 21-24).

We have previously held that approval of a lump sum award is expressly within the Director's discretion. ORS 656.230; Kevin E. Sahlfeld, 45 Van Natta 1779 (1993); Erven Simril, 43 Van Natta 629 (1991). The Board is without authority to authorize such an action.

In Sahlfeld, the parties' proposed agreement provided that the remaining unpaid balance of the claimant's permanent disability award would be accelerated and paid along with the CDA. We disapproved the disposition, reasoning that we were not authorized to permit such an action because the acceleration of permanent disability awards is an action which is expressly within the Director's discretion. ORS 656.230; Sahlfeld, supra.

In this CDA, however, we note that the parties are not requesting that the Board approve acceleration of permanent disability benefits. Rather, the CDA states that claimant retains the right to request a lump sum payment of any remaining balance of the permanent disability award.[1] We find

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[1] We find such an approach to be consistent with the Department's new rule, OAR 436-60-060(5) (effective August 28, 1994) which provides that a lump sum payment ordered in a litigation order or which is part of a CDA does not require further approval by the Division. WCD Admin. Order 94-055.

that such language merely acknowledges the preservation of claimant's entitlement to make such a request, rather than attempting to provide for Board approval of the action. Therefore, we conclude that the parties' language in this CDA is distinguishable from the language we rejected in Sahlfeld.

Accordingly, we conclude that the CDA in this instance is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Therefore, the parties' CDA is approved. An attorney fee of $5,475, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

September 14, 1994 Cite as 46 Van Natta 1859 (1994)

In the Matter of the Compensation of
DEBRA A. CANTERBERRY, Claimant
WCB Case No. 93-03980
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Davis' order that dismissed claimant's hearing request for lack of jurisdiction. On review, the issues are jurisdiction, interim compensation, and penalties and attorney fees. We reinstate claimant's hearing request, but conclude that claimant is not entitled to interim compensation benefits.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee reasoned that, by seeking interim compensation benefits, claimant was essentially contending that her claim had been misclassified as nondisabling. The Referee further concluded that the Director, not the Hearings Division, had jurisdiction to address reclassification of claimant's claim. On this basis, the Referee dismissed claimant's request for hearing.

We briefly recount the relevant facts. On August 28, 1993, a Sunday, claimant sought treatment at an emergency room for a chemical burn on her right hand. That same day, claimant was released to modified work by Dr. Welling. The only modification was that claimant wear gloves at work. Claimant did not work the next two days because these were scheduled days off. Claimant did not go to work on Wednesday because her right hand hurt. Claimant then worked four days with gloves. On the following Monday or Tuesday, the employer asked claimant to have a drug screen. The employer had a policy which provided for "suspicion" testing if the employer suspected that an employee has violated its anti-drug policy. Claimant was told not to return to work until she had the drug screen. Claimant believed that the employer was mad at her for filing a workers' compensation claim. Claimant did not have a drug screen and has not been back to work except to pick up her paycheck on March 15, 1993. Claimant's employment was terminated on that date. On May 25, 1993, the insurer accepted claimant's claim as nondisabling.

In Ralph E. Fritz, 44 Van Natta 1168 (1992), we held that we had jurisdiction to address a claimant's entitlement to interim compensation benefits in a claim that had been accepted as nondisabling. In Fritz, the claim had initially been classified as nondisabling. A Notice of Closure closed the claim. Thereafter, the claimant requested a hearing seeking interim compensation. We held that we did not have jurisdiction over issues pertaining to the Notice of Closure, but that we did have jurisdiction to consider the claimant's entitlement to interim compensation. We asserted jurisdiction over the interim compensation issue because we found, relying on Steven V. Bischof, 44 Van Natta 225, on recon 44 Van Natta 433 (1992), that the actual issue presented was the claimant's procedural entitlement to temporary disability benefits rather than the disabling/nondisabling issue which was within the Director's jurisdiction.

In the present case, claimant's claim has been accepted as nondisabling. Claimant has requested a hearing seeking interim compensation. We find no material distinction between Fritz and the present case. Fritz holds that the Board and Hearings Division have jurisdiction to address a claimant's entitlement to interim compensation benefits because that issue concerns the claimant's procedural entitlement to temporary disability rather than whether or not the claim is disabling or nondisabling. Accordingly, based on Fritz, we conclude that the Referee had jurisdiction to address claimant's "procedural" entitlement to interim compensation.

Although the Referee dismissed claimant's hearing request, testimony was taken and evidence was admitted concerning the interim compensation issue. Thus, we find that the record has been fully developed concerning the interim compensation and penalty and fee issues. Accordingly, we proceed to address the interim compensation and penalty and attorney fee issues.

In order to qualify for interim compensation, a claimant must establish that he or she has left work or suffered a loss of earnings as a result of an injury. Bono v. SAIF, 298 Or 405 (1977); RSG Forest Products v. Jensen, 127 Or App 247 (1994).

Here, we conclude that claimant has not established that she left work or lost earnings due to the injury. First, there is no evidence that time loss was ever authorized. In fact, Dr. Welling had released claimant for work. Second, the record indicates that claimant left work because she declined to take a drug screen and was terminated pursuant to the employer's drug testing policy. On this record, we are unable to conclude that claimant left work or lost earnings as a result of the injury. Accordingly, claimant has not established entitlement to interim compensation benefits. Because we conclude that claimant is not entitled to interim compensation, we likewise conclude that the insurer was not unreasonable in failing to pay these benefits. Thus, no penalties or attorney fees are warranted.

ORDER

The Referee's order dated November 10, 1993 is reversed. Claimant's hearing request is reinstated. The relief requested by claimant is denied.

In the Matter of the Compensation of
CATHERINE M. GRIMES, Claimant
WCB Case No. 93-06273
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of that portion of Referee Crumme's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation.

The Referee concluded that claimant had sustained her burden of proving that her repetitive employment activities were the major contributing cause of the worsening or development of her bilateral carpal tunnel syndrome. See ORS 656.802(1)(c); Aetna Casualty v. Aschbacher, 107 Or App 494 (1991). In so doing, the Referee relied on the medical opinion of Dr. Long, claimant's attending physician, who opined that claimant's repetitive work activities in the employer's packaging department were the major factor in the development of claimant's condition. We agree for the reasons cited by the Referee that there are no persuasive reasons not to defer to Dr. Long's opinion. See Weiland v. SAIF, 64 Or App 810 (1983).

On review, the insurer contends that Dr. Long's opinion is not well-reasoned or based on accurate and complete information. Specifically, the insurer asserts that Dr. Long's opinion is based on an unsupported "presumption" that wrist flexion, wrist extension, and contraction of the finger flexors produce elevation of extracellular pressure in the carpal canals. The insurer also argues that, even if Dr. Long's presumption is correct, his opinion is flawed because claimant's job did not involve significant wrist flexion or extension.

The insurer's contentions notwithstanding, we find that Dr. Long's medical opinion was well-reasoned and based on complete and accurate information. After concluding that claimant's work activities were the major contributing cause of her upper extremity conditions, Dr. Long stated:

> "The above opinion is based on the presumption that wrist flexion, wrist extension, and contraction of the finger flexors all produce elevation of extracellular fluid pressure in the carpal canals. Hand intensive work tends to increase pressure in the carpal canals, and this produces secondary chronic compression neuropathy involving the median nerves, usually at the distal edges of the carpal ligaments first, and then later at the proximal edges of the carpal ligaments. Chronic pain and paresthesias in association with median lesions in the wrists tend to provoke myofascial trigger points in the forearm flexors and extensors. Highly repetitive hand activity provokes myofascial trigger points in the forearm flexors and extensors. These physiologic circumstances, present over periods of months and years, produce symptomatic median nerve lesions and active trigger points in forearm muscles. The overall result is the critical pattern of symptoms that [claimant] presented when we evaluated her 9/27/93." (Ex. 12).

Although, as noted by the insurer, Dr. Long based his opinion on the "presumption" that wrist flexion and extension and contraction of finger flexors all produce elevation of fluid pressure in the carpal canals, Dr. Long explained in his deposition that this presumption was not controversial in the medical community and was supported by medical literature. (Ex. 14-5). Unlike the insurer, we are not troubled by Dr. Long's inability to cite specific articles to substantiate his opinion. We accept Dr. Long's testimony that this is not an area of controversy and that supporting data does exist. In short, we find that Dr. Long adequately explained the basis for his conclusion that claimant's carpal tunnel condition is related to her employment.

We also reject the insurer's assertion that Dr. Long did not have an accurate understanding of the nature of claimant's job duties. Dr. Long explained that his information about claimant's work

activities was gleaned from numerous sources: a videotape of the various jobs in the packaging department, claimant's description of her work duties, the history in the medical reports from examining physicians Drs. Nathan and Radecki, and general knowledge of claimant's place of employment. (Exs.14-9, 10). Dr. Long further explained that his opinion on causation was based on several sources such as claimant's work history, her avocational history, his understanding of the pathophysiology of peripheral nerve lesions and information regarding claimant's general medical health. (Ex. 14-10).

In summary, we agree with the Referee that Dr. Long's medical opinion is persuasive. In addition, we find it more convincing than the medical opinions of Drs. Nathan and Radecki, on whom the insurer would have us instead rely.

Dr. Nathan, who initially treated claimant at the suggestion of the employer and who later examined claimant on behalf of the insurer, disagreed with Dr. Long's opinion on causation. He wrote that Dr. Long did not analyze factors "intrinsic" to claimant, including age, body mass, activity level, wrist ratio, gender and hand dominance, which may "predispose" claimant to development of median entrapment neuropathy. (Ex. 10-2). Based in part on statistical association, Dr. Nathan concluded that the "intrinsic factors" mentioned above put claimant at a greater risk of developing median entrapment neuropathy, i.e., carpal tunnel syndrome, than her employment did. (Ex. 10-3).

We do not find Dr. Nathan's opinion sufficient to negate work-related causation of claimant's condition. First, we find that, in the absence of an explanation in this record of how they actually cause median entrapment neuropathy, the "intrinsic factors" to which Dr. Nathan refers merely predispose claimant to the development of carpal tunnel syndrome. Thus, we do not include them in the major contributing cause calculus. See Liberty Northwest v. Spurgeon, 109 Or App 566, 570 (1991) (idiopathic factors which predispose a worker to, but do not cause, an occupational disease are not considered in the determination of major causation).

Second, Dr. Nathan's opinion is based largely on the alleged statistical correlation between carpal tunnel syndrome and the intrinsic factors Dr. Nathan identified. We find such evidence unpersuasive with respect to the causation of carpal tunnel in this particular claimant. See Mark Ostermiller, 46 Van Natta 1556 (1994) (medical opinions based on statistical correlation or association between certain risk factors and carpal tunnel syndrome insufficient to establish causation).

The same concerns that lead us to discount Dr. Nathan's medical opinion also cause us to discount Dr. Radecki's opinion. Although Dr. Radecki opines that claimant's age, obesity and increased wrist ratio are the major contributing cause of claimant's carpal tunnel condition, his medical report and deposition testimony also fail to adequately explain how these factors actually caused the carpal tunnel condition in this claimant. (Exs. 7, 13-11, 21). For this reason, we also conclude that Dr. Radecki's medical opinion supports our conclusion that these factors predisposed claimant to developing carpal tunnel syndrome, rather than caused the condition. Liberty Northwest Ins. Corp. v. Spurgeon, supra.

Moreover, like Dr. Nathan, Dr. Radecki also relies on statistical association between unsubstantiated intrinsic factors, such as age, obesity, and wrist ratio, and carpal tunnel syndrome. (Ex. 13-21, 22, 27, 28). For this reason as well, we give reduced weight to Dr. Radecki's opinion. Mark Ostermiller, supra.

In summary, on this record, we are more persuaded by the opinion of Dr. Long, claimant's treating physician. We conclude that claimant has proved that his bilateral carpal tunnel condition is compensable. See ORS 656.802(2).

Claimant's counsel is entitled to attorney fees for services on review concerning the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review regarding the compensability issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated February 7, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
SUZEANN EVANS, Claimant
WCB Case No. 93-10836
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee Menashe's order that: (1) increased claimant's unscheduled permanent disability award for a cervical injury from 51 percent (163.2 degrees), as awarded by an Order on Reconsideration, to 60 percent (192 degrees); and (2) assessed a penalty pursuant to ORS 656.268(4)(g). On review, the issues are extent of unscheduled permanent disability and penalties.

We adopt and affirm the Referee's order except for that portion regarding the extent of impairment for a cervical condition, for which we provide the following supplementation.

The employer challenges the Referee's finding that claimant proved 19 percent impairment based on loss of range of motion for a cervical condition. The Referee based that finding on a medical arbiter's report. The employer argues that the medical arbiter's report is not reliable due to claimant's proven lack of credibility. (App. Br. at 4).

In support of its argument, the employer cites Referee Lipton's November 10, 1992 order from a prior hearing upholding the employer's denial of claimant's occupational disease claim for a carpal tunnel condition. (Ex. 131). At that hearing, the employer impeached claimant's testimony that she had done very little gardening since 1989 by introducing surveillance video tape showing claimant using scissors in her garden. (Ex. 131-4). Referee Lipton concluded that: "Taken together with the fact that claimant can and does do more off work than she is willing to tell her doctors, the histories relied upon are unreliable and further diminish the weight to be given to the physicians' opinions." (Ex. 131-5).

Claimant's nonwork activities are not at issue in this proceeding. The preponderance of medical evidence establishes that claimant has a cervical condition arising from her April 1989 compensable injury. At issue is the extent of permanent disability for that cervical condition. Consequently, Referee Lipton's previous findings regarding claimant's occupational disease claim for carpal tunnel syndrome have little bearing on our current deliberations.

Therefore, inasmuch as neither Referee Menashe nor the medical arbiters found claimant to be unreliable, we conclude that claimant's credibility in this proceeding is not impeached by the surveillance tape and findings of fact arising from the earlier adjudication of her occupational disease claim for carpal tunnel syndrome. See generally, Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

The employer also cites current instances where claimant's physicians question the reliability of her responses. In a written response to an inquiry from the employer's counsel, Dr. Grewe, claimant's treating neurological surgeon, stated:

> "Impairment is felt to be secondary to her C3-4 fusion procedure, as well as some limitation of cervical range of motion due to her pain syndrome residual. Formal range of motion testing with an inclinometer has not been performed. I suspect this may not be reliable. Overall, I would crudely estimate her limitations as 'moderate.'" (Emphasis supplied) (Ex. 136).

Because Dr. Grewe did not measure claimant's range of motion, his opinion is purely speculative with regard to claimant's actual range of motion findings. Consequently, his opinion is not persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Moreover, although Dr. Grewe questions the validity of claimant's range of motion responses, he nonetheless concludes that claimant is "moderately" limited. (Emphasis supplied) (Ex. 136). The

medical arbiters, who did not express any reservations regarding the validity of claimant's cervical range of motion measurements, found: "objective evidence to suggest [claimant] has a mild permanent restriction concerning neck motion relevant to the condition." (Emphasis supplied) (Ex. 161-3). Therefore, to the extent that Dr. Grewe addressed impairment, his opinion does not contradict that of the medical arbiters.

As further proof of claimant's unreliability for truthfulness, the employer relies upon the medical opinions of Dr. Zivin (neurologist) and Dr. Ploss (specializing in occupational medicine); neither doctor is an attending physician. (Exs. 103 & 132).

In Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994), the court held:

> "An independent medical examiner's impairment findings that the employer offers for impeachment are, nonetheless, findings regarding the worker's impairment that evaluate the disability. The legislature intended to permit only the attending physician to make such findings. The Board violated ORS 656.245(3)(b)(B) by receiving and considering the impairment findings of an independent medical examiner."

Pursuant to Koitzsch, we do not consider the medical opinions of Dr. Zivin or Dr. Ploss in calculating the extent of claimant's unscheduled permanent disability. See also Libbett v. Roseburg Forest Products, 130 Or App 50 (1994).

Moreover, the medical arbiters expressed no doubts regarding the reliability of claimant's cervical range of motion as measured by double inclinometer. (Ex. 161-3). Finding no reason to question the validity of claimant's range of motion as arrived at by the medical arbiters, we rely exclusively on their determination regarding the extent of claimant's unscheduled permanent disability. Id.; see generally, Somers v. SAIF, 77 Or App 259, 263 (1986); see also ORS 656.268(7).

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of unscheduled permanent disability is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee award for services on review regarding the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated January 4, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
FRANKLIN L. KUNTZ, Claimant
WCB Case No. 93-09684
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Michael Fetrow (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Menashe's order that affirmed an Order on Reconsideration which did not award permanent disability. Claimant seeks remand for the appointment of a medical examiner and the consideration of that examiner's future report. On review, the issues are remand and the extent of unscheduled permanent disability.

We adopt and affirm the Referee's order with the following supplementation.

Claimant's claim was closed by a November 20, 1992 Determination Order that awarded no permanent disability. (Ex. 21). On May 12, 1993, claimant, through his attorney, requested reconsideration of the Determination Order and also requested a medical arbiter examination. (Ex. 29).

A medical arbiter examination was scheduled, and on May 28, 1993, notice of the examination was sent to claimant at the same address given by claimant's attorney in the request for reconsideration. (Ex. 33). The notice stated that if claimant did not keep the appointment, his claim would be reviewed based on the information in the file when his claim was closed. A copy of the notice was also sent to claimant's attorney. (Id.) However, claimant did not attend the examination. The medical arbiter notified SAIF and claimant's attorney of the failed appointment on June 23, 1993. (Ex. 35).

Although claimant testified that he moved on April 15, 1993, there is no evidence that claimant notified the Department or his attorney that his address had changed. An Order on Reconsideration issued on August 4, 1993 which affirmed the Determination Order based upon the record developed at the time of claim closure. (Ex. 36). Between June 23, 1993 and August 4, 1993, neither claimant nor his attorney notified the Department that claimant wished to have the medical arbiter examination rescheduled. On August 10, 1993, claimant, through his attorney, requested a hearing on the Order on Reconsideration and used the same address given by claimant in his request for reconsideration.

The Referee found that claimant did not receive the letter notifying him of the medical arbiter's examination. The Referee noted that if claimant had notified the Department that he was unaware of the arbiter examination, another examination conceivably could have been rescheduled and considered in this proceeding. The Referee concluded that the fact that claimant did not receive notice of the arbiter's examination did not nullify the reconsideration process. Turning to the merits of the permanent disability issue, the Referee affirmed the Order on Reconsideration which did not award permanent disability.

Claimant requests that we remand the case to the Referee to appoint a medical examiner pursuant to OAR 438-07-005(5) to conduct a medical examination in lieu of the medical arbiter's examination to determine the extent of his disability. We decline to grant claimant's request.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

In the present case, there is not a compelling reason to justify remanding this case to the Referee because a medical arbiter's examination was "obtainable" before the hearing. OAR 436-10-047(5) provides that when a worker is required to attend a medical arbiter examination, "the director shall send notice of the examination to the worker and all affected parties." The Director complied with this rule

by sending notice of the medical arbiter's examination to the same address given by claimant (by his attorney) in the request for reconsideration. (Ex. 33). The Director further explained to claimant, through his counsel, that failure to attend the examination would prompt the Department to perform a record review.

We conclude that claimant was constructively notified of the medical arbiter examination. In this regard, there is no evidence that claimant advised the Department or his attorney of a change of address and no proof that the notice of the medical arbiter examination was returned to the Department as undeliverable. See Joyce E. Mitts, 42 Van Natta 972 (1990) (Where current address of a party was provided to the Hearings Division in another case, but not to the Board in the case in question, and a copy of the Board's order, which was mailed to that party at address provided to the Board, was not returned as undeliverable, the order had been mailed to all parties and was final). In fact, the address claimant's attorney gave for claimant in his May 12, 1993 request for reconsideration was the same address to which the Department mailed its notice of the medical arbiter examination on May 28, 1993. Based on this evidence, we are unable to conclude that claimant did not receive notice of the medical arbiter examination. See Mario M. Labra, 46 Van Natta 1183 (1994).

The remaining question is whether claimant waived his right to a medical arbiter's examination. In Mario M. Labra, supra, we concluded that because the claimant had failed to attend the medical arbiter's examination, without mitigating or just cause, the claimant waived his right to a medical arbiter's examination. We reach the same conclusion in this case. See also Craig K. Witt, 45 Van Natta 1285 (1993).

Here, claimant, through his attorney of record, was notified of the examination, as well as the ramifications if he did not attend that examination. OAR 436-30-050(11)(a) provides that if a worker requests reconsideration and the worker fails to appear for the medical arbiter exam, the record developed at the time of the closure will be used to issue the reconsideration order. The arbiter examination notice sent to claimant advised him of this possibility. Claimant's attorney was mailed a copy of the notice of arbiter examination and a copy of the letter from the medical arbiter concerning the failed appointment. Thereafter, neither claimant nor his attorney objected to a record review or sought rescheduling of the arbiter examination during the nearly two months between the notice of failed appointment and the issuance of the reconsideration order. Under such circumstances, we conclude that claimant waived his right to a medical arbiter's examination.

Claimant argues that the result of the Referee's order deprives him of the due process right that the legislature has determined that he is entitled to in an extent case, i.e., to challenge the treating physician's findings. Claimant contends that ORS 656.268(7) provides him with an "unqualified right" to establish actual impairment by a thorough examination.

We do not agree that claimant was deprived of his right to due process. ORS 656.268(7) provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director." (Emphasis added).

The Director complied with ORS 656.268(7) when a medical arbiter examination was scheduled for June 23, 1993. (Ex. 33). Claimant was constructively notified of the examination, but waived his right to a medical arbiter examination. As discussed above, OAR 436-30-050(11)(a) provides that if a worker fails to appear for the medical arbiter exam, the record developed at the time of closure will be used to issue the reconsideration order.

In any event, even if we were to grant the remedy requested by claimant, it is not reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., supra. With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure can make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994) (Board violated ORS 656.245(3)(b)(B) by receiving and considering impairment findings of an independent medical examiner). Impairment

findings from a physician, other than the attending physician, may be used, however, if those findings are ratified by the attending physician. See Roseburg Forest Products v. Owen, 129 Or App 442 (1994). Even if we grant the relief that claimant seeks, i.e., appointment of a medical examiner and consideration of that examiner's future report, we cannot consider those impairment findings unless they are ratified by claimant's attending physician.

Accordingly, we conclude that there is not a compelling reason to justify remanding this case to the Referee. Consequently, the motion to remand is denied.

We turn to the merits of the permanent disability issue. After conducting our review of the record, we adopt the Referee's conclusion that claimant has not established entitlement to a permanent disability award.

ORDER

The Referee's order dated December 3, 1993 is affirmed.

September 16, 1994 Cite as 46 Van Natta 1867 (1994)

In the Matter of the Compensation of
PAMELA BLUMENSHINE, Claimant
WCB Case Nos. 93-10980 & 93-06741
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The noncomplying employer requests review of Referee Podnar's order which set aside the SAIF Corporation's denial of claimant's injury claim. On review, the issue is subjectivity.

We adopt and affirm the Referee's order, with the following supplementation.

The employer asserts two arguments to support its contention that claimant failed to establish a permanent employment relationship. First, it argues that claimant terminated her Oregon employment when she quit the Coos Bay job. Second, the employer contends that claimant's subsequent work involved a series of independent, discrete employment. We reject both arguments.

Claimant began working for the employer (a utility contractor) on July 30, 1990. She primarily worked as a flagger, but also performed laborer work. Claimant began the Coos Bay job in early June 1991 and left that job on June 16, 1991 for personal reasons. When she left, claimant told her foreman that if there was work available in the Portland area that she would be glad to do it. Her foreman informed claimant that if work was available that he would rehire her. Shortly after leaving the Coos Bay job, claimant worked for the employer at a number of job sites in Oregon. Given the nature of the employer's business and its continued employment of claimant after the Coos Bay job, we do not find that the employment relationship between the employer and claimant ended when she quit her job at Coos Bay.

Contrary to the employer's assertion, these subsequent jobs did not represent discrete periods of employment. When employees are transient and work in various locations in more than one state, we look at more than simply the sequence of assignments. Rather, all the circumstances of the employment relationship are relevant. Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186, 190 (1992).

Here, the employer operates in Oregon, Idaho and Washington and employs workers in these states. The availability of the employer's work is contingent upon successful approval of bids. The employer allowed claimant to accept or reject a particular job assignment. The employer was aware that claimant wanted to work closer to her Portland home. Until the job in Washougal, Washington, claimant's job assignments were only in Oregon.

Based on the record as a whole, we find that the circumstances surrounding claimant's work assignments establish a permanent employment relationship between the employer and claimant before the out-of-state injury occurred. Claimant has, thus, established that she was an Oregon subject worker at the time of her injury.

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,600, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 25, 1994 is affirmed. Claimant's attorney is awarded $1,600 for services on Board review, to be paid by the SAIF Corporation on behalf of the noncomplying employer. Our Interim Order of Dismissal, dated April 19, 1994, is incorporated by reference herein.

In the Matter of the Compensation of
ROBERT W. NORTH, Claimant
WCB Case Nos. 91-16198 & 91-16197
ORDER ON REVIEW
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of Referee McCullough's order that: (1) found that claimant's neck injury claim was not prematurely closed; (2) set aside a December 31, 1991 Order on Reconsideration; (3) reinstated and affirmed an October 14, 1991 Notice of Closure; (4) did not award additional temporary disability compensation; (5) upheld the insurer's denial of claimant's consequential and occupational disease claims for a psychological condition; (6) upheld the insurer's denial of claimant's current neck condition; (7) did not assess penalties for the insurer's allegedly unreasonable denial of claimant's psychological condition and current condition claims; and (8) declined to assess a penalty for the insurer's failure to pay temporary disability benefits. On review, the issues are compensability, premature closure, temporary disability compensation, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

Claimant's claim for a July 1991 neck injury was closed by Notice of Closure on October 14, 1991, finding claimant medically stationary on October 8, 1991. Claimant requested reconsideration of the Notice of Closure. On October 17, 1991, the insurer denied compensability of claimant's ongoing neck condition.

A December 31, 1991 Order on Reconsideration held that the claim was prematurely closed, rescinded the October 1991 Notice of Closure, and ordered that claimant's July 1991 claim remain in open status.

On January 21, 1992, the insurer appealed the Order on Reconsideration to the Hearings Division. Thereafter, the insurer neither closed claimant's claim nor paid temporary disability benefits.

CONCLUSIONS OF LAW AND OPINION

Compensability/Psychological and Current Conditions

We adopt and affirm the Referee's opinion as it pertains to these issues.

Premature Claim Closure

We adopt and affirm the Referee's opinion which found that the claim was not prematurely closed by the October 14, 1991 Notice of Closure.

Temporary Disability Compensation

Prior to Order on Reconsideration

We adopt and affirm this portion of the Referee's opinion, with the following supplementation.

We have herein found that claimant's claim was not prematurely closed. Thus, the October 14, 1991 Notice of Closure finding claimant medically stationary on October 8, 1991 is affirmed. Under these circumstances, we are without authority to award temporary benefits between the date claimant became medically stationary and the date of the Order on Reconsideration. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992) (a claimant is substantively entitled to payment of temporary disability benefits only through the medically stationary date; the Board cannot impose a procedural overpayment).

During Pendency of Insurer's Appeal

The December 31, 1991 Order on Reconsideration held that claimant's July 1991 claim was prematurely closed, rescinded the October 14, 1991 Notice of Closure, and ordered that claimant's claim remain in open status. The insurer requested a hearing from the Order on Reconsideration. The insurer did not pay additional temporary disability benefits after the reconsideration order issued.

On review, claimant questions the insurer's refusal to resume paying temporary disability benefits when the Order on Reconsideration rescinded claim closure. The insurer argues that, because it denied compensability of claimant's ongoing neck condition on October 17, 1991, claimant's entitlement to additional temporary disability was precluded by that denial.

Inasmuch as the insurer's current condition denial issued while the claim was in open status (by virtue of the subsequent Order on Reconsideration), the denial constitutes an impermissable "pre-closure" denial of an accepted claim. See Sheridan v. Johnson Creek Market, 127 Or App 259 (1994); United Airlines, Inc. v. Brown, 127 Or App 253 (1994). Moreover, we find that the insurer was statutorily obligated, under ORS 656.313, to pay compensation accruing from the date of the Order on Reconsideration until the Referee reversed and set aside the Notice of Closure.

ORS 656.313 provides, in relevant part:

> "(1)(a) Filing by . . . the insurer for hearing from a reconsideration order . . . stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs[.]" (Emphasis added).

The exception created by subsection (A) of ORS 656.313, creates a statutory obligation to pay temporary disability compensation awarded by an appealed order on reconsideration. Moreover, the insurer is required to pay the temporary disability benefits that accrue during the pendency of the appeal, regardless of the outcome of the appeal. Anodizing, Inc. v. Heath, 129 Or App 356-57 (1994); Pascual Zaragoza, 45 Van Natta 1221, 1223 (1993), aff'd mem Zaragoza v. Liberty Northwest Insurance Corp., 126 Or App 544 (1994); Roseburg Forest Products v. McDonald, 116 Or App 448 (1992).

Thus, once the insurer appealed from the reconsideration order, it was required to resume paying claimant temporary disability benefits until such time as the claim was either closed under ORS 656.268, or a referee issued an order reinstating the Notice of Closure. The insurer chose not to avail itself of closure under ORS 656.268. Under these circumstances, claimant's temporary disability benefits continued to accrue through the date of the Referee's order reinstating the Notice of Closure. Consequently, claimant is entitled to an award of temporary disability benefits from December 31, 1991 through December 17, 1993, the date of the Referee's order reversing the Order on Reconsideration.

Because our award of temporary disability benefits does not create an overpayment that is prohibited by Lebanon Plywood v. Seiber, supra, the insurer may not recoup these payments from claimant out of future awards of compensation. ORS 656.313(2); Anodizing, Inc. v. Heath, supra; Roseburg Forest Products v. McDonald, supra.

Finally, since claimant was represented by an attorney at hearing, his former counsel is entitled to a portion of this temporary disability award. Consistent with OAR 438-15-045, that attorney fee shall equal 25 percent of the increased compensation created by this order, not to exceed $1,050, payable directly by the insurer to claimant's former attorney.

Penalties

Denial/Psychological and Current Condition Claims

As we have affirmed the Referee's order finding claimant's psychological and current condition claims not compensable, we conclude that the insurer's denials were not unreasonable. Accordingly, no penalty shall be assessed.

Failure to Pay Temporary Disability

The Referee reasoned that, because the insurer had a legitimate basis to doubt that claimant continued to be disabled after October 8, 1991, its failure to pay temporary disability was not unreasonable. We disagree. Inasmuch as the insurer was statutorily and administratively required to pay temporary disability benefits during the pendency of the appeal, we conclude that its failure to recommence the payment of temporary disability effective with the December 31, 1991 Order on Reconsideration was unreasonable. See ORS 656.313; OAR 436-60-150(4)(e); Anodizing, Inc. v. Heath, supra; Pascual Zaragoza, supra; Roseburg Forest Products v. McDonald, supra.

ORS 656.262(10)(a) provides, in pertinent part, that "[i]f the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, * * * , the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due." In light of the clear directive contained in ORS 656.313(1)(a)(A) and OAR 436-60-150(4)(e), we conclude that the insurer's failure to pay temporary disability after the December 31, 1991 Order on Reconsideration directed that claimant's July 1991 claim remain in open status was unreasonable. Consequently, we assess a penalty of 10 percent based on the amount of temporary disability benefits for the period December 31, 1991 (the date of the Order on Reconsideration) through December 17, 1993 (the date of the Referee's order).

ORDER

The Referee's order dated December 17, 1993 is affirmed in part and reversed in part. Claimant is awarded temporary disability from December 31, 1991 through December 17, 1993. Claimant's former attorney is awarded 25 percent of the increased compensation created by this order, not to $1,050, payable directly by the insurer to claimant's former attorney. The insurer is also directed to pay to claimant a penalty equal to 10 percent of the temporary disability benefits which should have been paid from December 31, 1991 through December 17, 1993. The remainder of the order is affirmed.

Board Chair Neidig specially concurring.

The insurer contends that its failure to recommence payment of temporary disability pending its appeal from the Order on Reconsideration was not unreasonable because it had previously issued its denial of claimant's current neck condition and had been notified that claimant's attending physician concurred with an independent medical examiner's report that claimant's condition was medically stationary. My examination of the record confirms that such circumstances existed. Nonetheless, it does not necessarily follow that such events provide the insurer with the authority to effectively terminate claimant's temporary disability before it has recommenced such benefits as directed by the Order on Reconsideration. In fact, ORS 656.313(1)(a)(A) unambiguously exempts prospective temporary disability from the "stay of compensation" provision.

I recognize that the insurer was dissatisfied with the Order on Reconsideration which set aside its Notice of Closure. Nevertheless, rather than refusing to pay temporary disability and to further process the claim in response to the reconsideration order, the insurer should have either taken appropriate measures to secure the statutory authorization to terminate claimant's temporary total disability under ORS 656.268(3) or to prepare the claim for re-closure under ORS 656.268(2) or (4). It is this claim processing omission that has led to the assessed penalty.

In the Matter of the Compensation of
SUSAN K. MARLNEE, Claimant
WCB Case No. 93-12153
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee Neal's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left forearm (wrist) from 24 percent (36 degrees), as awarded by an Order on Reconsideration, to 28 percent (42 degrees); (2) affirmed an Order on Reconsideration assessing a penalty under ORS 656.268(4)(g); and (3) awarded claimant an attorney fee under ORS 656.382(2). On review, the issues are extent of scheduled permanent disability, penalties, and attorney fees. We modify in part, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

The employer accepted bilateral carpal tunnel syndrome. Claimant was medically stationary on December 3, 1992, and her claim was closed by Notice of Closure on February 1, 1993, with no award of permanent disability.

Claimant continued to perform repetitive work activity. Because she was not improving as expected, on May 21, 1993, claimant returned to Dr. Eisler. The doctor noted that claimant had not had a good response to left carpal tunnel release surgery, and took claimant off work.

Dr. Layman became claimant's treating physician. Dr. Layman examined claimant on July 26, 1993 and reported that claimant's wrist range of motion was "full," but that claimant had reduced grip and pinch strength in the left hand.

Dr. Gehling performed a medical arbiter's examination on August 31, 1993. Dr. Gehling measured claimant's ranges of motion, tested claimant's two-point discrimination, and graded claimant's muscle strength. Based on Dr. Gehling's report, the September 13, 1993 Order on Reconsideration awarded claimant 24 percent scheduled permanent disability, and assessed a penalty under ORS 656.268(4)(g).

Claimant requested reopening of the claim for aggravation on September 3, 1993. The employer notified claimant's counsel that there was no objective medical evidence of worsening. Claimant's counsel contacted Dr. Eisler concerning objective findings that would support a worsening of claimant's carpal tunnel condition. In response, Dr. Eisler clarified that he took claimant off work not because of a worsening of her condition but, rather, as a preventative measure. Thereafter, claimant did not pursue the aggravation claim.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Disability

The Referee found that claimant was entitled to 5 percent for a chronic condition. Thus, combining this value with claimant's other impairment values, the Referee increased claimant's award of scheduled permanent disability to 28 percent. We modify.

On review, the employer contends that the Referee improperly relied on the medical arbiter's report to award claimant any permanent disability. First, the employer asserts that Arbiter Gehling evaluated claimant during a temporary worsening of her condition. We find, as did the Referee, that the medical evidence and claimant's testimony indicate that claimant's condition did not worsen in 1993.

Further, the employer asserts that attending physician Layman's September 17, 1993 report, not the arbiter's report, was closer to the September 13, 1993 Order on Reconsideration. Dr. Layman conducted a closing examination on September 17, 1993, after Dr. Gehling's August 31, 1993 medical arbiter's examination. ORS 656.268(7) prohibits the admission of medical evidence of the worker's impairment developed after the medical arbiter's report. Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993); see e.g., Jim Vallejo, 46 Van Natta 1242 (1994). Thus, the prohibition of ORS 656.268(7) is applicable.

Likewise, Dr. Layman's September 10, 1993 report was developed after the medical arbiter's report. Thus, it is also inadmissible under ORS 656.268(7) for purposes of evaluating claimant's permanent disability. Only Dr. Layman's July 1993 report was developed prior to the issuance of Dr. Gehling's August 1993 medical arbiter report. Therefore, we do not consider Dr. Layman's September 10, 1993 or September 17, 1993 medical reports for purposes of determining claimant's impairment. Instead, claimant's permanent disability is to be rated considering Dr. Layman's July 1993 and and Dr. Gehling's arbiter's report. ORS 656.245(3)(b)(B); ORS 656.268(7).

Next, the employer argues that it is "unclear" whether the arbiter's findings and opinions were affected by claimant's noncompensable hand conditions. To the contrary, it was the arbiter who pointed out that claimant has degenerative changes in the base of her thumb and in the bones in her hands, and then specifically noted that these conditions "obviously" were not related to claimant's accepted carpal tunnel syndrome. Dr. Gehling measured claimant's ranges of motion, tested claimant's two-point discrimination, and graded claimant's muscle strength, and opined that the findings were related to claimant's carpal tunnel conditions and left carpal tunnel release. Accordingly, we find Gehling's arbiter's examination of claimant to be a thorough and accurate evaluation of claimant's impairment.

Finally, the employer contends that the Referee improperly relied on Dr. Layman to award claimant a "chronic condition" award. We agree.

The only evidence which supports an award for a "chronic condition is Dr. Layman's September 10, 1994 report. As noted above, Dr. Layman's September 10, 1994 report cannot be considered as it was developed after the medical arbiter's report. Consequently, claimant has not established that she is entitled to an impairment value for a chronic condition. Based on Dr. Gehling's medical arbiter report, we conclude that claimant is entitled to 24 percent scheduled permanent disability. Therefore, we modify the Referee's order accordingly.

Penalties

ORS 656.268(4)(g) authorizes assessment of a penalty against an insurer or self-insured employer if, upon reconsideration of a notice of closure, the following two conditions are met: (1) the claimant is found to be at least 20 percent permanently disabled; and (2) the Department orders an increase by 25 percent or more of the amount of compensation to be paid to the claimant for permanent disability. If the statutory requirements are met, the claimant is automatically entitled to the penalty, without regard to whether the carrier's action was reasonable. Kevin Northcut, 45 Van Natta 173 (1993).

Asserting that its conduct was not unreasonable, the employer urges us not to rely on Northcut, supra. We recently declined to reconsider our decision in Northcut. See Vernal M. Davidson, 46 Van Natta 704 (1994) (continuing to hold that if the statutory requirements are met, a claimant is automatically entitled to a penalty under ORS 656.268(4)(g)).

Finding that the statutory requirements were met, on reconsideration, the Appellate Unit assessed a penalty under ORS 656.268(4)(g). We agree with the Appellate Unit's determination that both statutory conditions were satisfied. Accordingly, claimant is entitled to the penalty assessed by the Appellate Unit. Davidson, supra; Northcut, supra.

Attorney Fees

Because we have affirmed the scheduled permanent disability awarded by the Order on Reconsideration award of 24 percent, we do not disturb the Referee's ORS 656.382(2) attorney fee award for prevailing over the employer's request for hearing.

Inasmuch as attorney fees are not considered compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to an attorney fee award for services on review defending the Referee's attorney fee assessment. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986). Finally, because imposition of a penalty under ORS 656.268(4)(g) does not constitute grounds for awarding an assessed attorney fee under ORS 656.382(2), claimant is not entitled to an attorney fee award for services on review regarding the Appellate Unit's penalty assessment. See Beverly A. Kirk, 45 Van Natta 886 (1993).

ORDER

The Referee's order dated February 1, 1994, as reconsidered March 1, 1994, is modified in part, reversed in part and affirmed in part. In lieu of the Referee's increased award, the Order on Reconsideration's award of 24 percent (36 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist) is reinstated and affirmed. The Referee's "out-of-compensation" attorney fee award is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MELVIN L. NELSON, Claimant
WCB Case Nos. 92-16492 & 93-01866
SECOND ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On August 22, 1994, we issued an Order on Reconsideration rejecting the self-insured employer's argument that it was entitled to offset temporary disability it paid pursuant to the Department's Order on Reconsideration to the date of the hearing, against additional permanent disability awarded by the Order on Review. In reaching this conclusion, we construed ORS 656.313(2) as also including a request for hearing and, therefore, found that the legislature intended to insure that a claimant would not be obligated to repay compensation paid pending the filing of a request for hearing. Based on this reasoning, we found no entitlement to an offset of temporary disability paid pending the hearing.

The employer has filed a second request for reconsideration, asserting that the Board's order is contrary to Ray Graves, 42 Van Natta 2425 (1990). The employer also asserts that the Board's construction of ORS 656.313(2) is "incorrect."

Inasmuch as Ray Graves, supra, concerned the former version of ORS 656.313, we find it inapplicable to this case. Furthermore, based on the reasoning in our Order on Reconsideration, we continue to adhere to our conclusion that the employer is not entitled to offset temporary disability it paid pending the hearing.

We withdraw our August 22, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our August 22, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LYNDA C. PROCIW, Claimant
WCB Case Nos. 93-09391 & 93-09390
ORDER ON RECONSIDERATION
Johnson, Cram & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys
Marcia L. Barton (Saif), Defense Attorney

Claimant requests reconsideration of our August 23, 1994 Order on Review that affirmed Arbitrator Nichols' order that: (1) set aside Liberty's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS); and (2) upheld the SAIF Corporation's denial of the same condition. Specifically, claimant argues that we erred in declining to award an attorney fee for her counsel's services on review. After considering claimant's motion, we proceed with our reconsideration of this matter.

In our August 23 order, we said, "Because our review is pursuant to ORS 656.307(2), claimant's counsel is not entitled to an attorney fee award for services on review. See ORS 656.307(5); Keenon v. Employers Overload, 114 Or App 344 (1992)." (Order on Review at 2). Claimant argues that Keenon does not support our decision not to award an attorney fee on review. We disagree.

ORS 656.307(5) provides:

> "The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable attorney fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be the party responsible for paying the claim." (Emphasis added.)

On its face, ORS 656.307(5) authorizes an arbitrator to award an attorney fee for services at hearing; there is no provision for a fee on review. See Frances P. Keenon, 43 Van Natta 1325 (1991), aff'd in part Keenon v. Employers Overload, supra (remanded for reinstatement of attorney fee award for "pre-307 order" services; otherwise Board's rejection of attorney fee award for services at proceeding and on review affirmed); Ernest C. Blinkhorn, 42 Van Natta 2597 (1990).

Although claimant is not entitled to an attorney fee pursuant to ORS 656.307(5), we conclude, on reconsideration, that claimant has established entitlement to an attorney fee pursuant to ORS 656.382(2). In that regard, as established by the Department's "307 order," claimant's temporary total disability rate under her Liberty claim ($147.76) is greater than her rate under her SAIF claim ($82.85). (Ex. 30). Therefore, had Liberty's appeal of the Arbitrator's decision finding it responsible proved successful, claimant's compensation would have been reduced. Because there was a risk that claimant's compensation would be reduced on review had we found SAIF responsible, claimant is entitled to an insurer-paid attorney fee for services on review, to be paid by Liberty. See Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991); Ollie D. Wigger, 43 Van Natta 261 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $900, to be paid by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

Accordingly, our August 23, 1994 order is withdrawn. On reconsideration, as modified herein, we adhere to and republish our August 23, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALLAN R. ROEDER, Claimant
WCB Case No. 93-11303
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee Livesley's order that: (1) concluded that SAIF's current condition and aggravation denial of claimant's neck and right arm complaints is barred by res judicata; and (2) assessed a penalty and attorney fee for the allegedly unreasonable denial. On review, the issues are res judicata, compensability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable C5-C6 disk herniation while working for SAIF's insured in July 1990. Claimant has severe degenerative disk disease in the cervical spine which preexisted the 1990 injury.

The 1990 injury claim was closed in February 1991. In late 1992, claimant began experiencing increased neck and right arm symptoms. On April 9, 1993, SAIF issued a current condition/aggravation denial and responsibility disclaimer.

Claimant challenged the denial and a hearing was held before Referee Crumme. In an August 18, 1993 Opinion and Order, Referee Crumme found that a claim had not been filed for the current neck and right arm symptoms, and that SAIF's denial was premature. The Board has affirmed Referee Crumme's decision. Allan R. Roeder, 46 Van Natta 1671 (1994).

Subsequent to issuing the April 9, 1993 denial, SAIF received numerous medical billings for treatment for claimant's neck and right arm complaints. (Exs. 6, 8, 10, 11, 14, 16, 17). After receiving these billings, SAIF issued a second aggravation/current condition denial and responsibility disclaimer on September 22, 1993, and an amended denial and disclaimer on October 28, 1993. (Exs. 19, 20). Claimant requested a hearing on the denials.

Claimant's 1990 injury combined with his preexisting degenerative disk disease to cause his current neck and right arm symptoms. Claimant's preexisting degenerative disk disease is the major cause of his current symptoms and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the prior litigation before Referee Crumme operated as a res judicata bar to the September and October 1993 denials. The Referee also concluded that the denials were unreasonable and warranted a penalty and attorney fee. On review, SAIF challenges the Referee's res judicata ruling and assessment of a penalty and fee. In addition, SAIF contends that claimant's current neck and right arm condition is not compensable on the merits.

We begin our analysis with the Referee's res judicata ruling. Under the res judicata doctrine of "claim preclusion," if a claim is litigated to a final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Restatement (Second) of Judgments, Sect. 17-19, 24; see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den, 289 Or 337 (1980). Under the doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined by a valid and final judgment, and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. North Clackamas School District v. White, 305 Or 48, 53, modified, 305 Or 468 (1988).

Here, the merits of claimant's current neck and right arm condition were not litigated in the prior proceeding before Referee Crumme. That litigation, instead, established that no claim had been filed for claimant's current condition. Thus, there was no final judgment in a claim giving rise to a claim preclusion bar. Nor was there a final judgment on the compensability issue raised by the denials presently before the Board. Thus, these denials are not barred by claim or issue preclusion.

Accordingly, consistent with the above discussion, we reverse the Referee's ruling that SAIF's September 22, 1993 and October 28, 1993 denials were barred by res judicata. In light of our ruling on this issue, we also reverse the Referee's assessment of a penalty and attorney fee for these denials.

We turn to the merits of the compensability issue. The medical evidence establishes that claimant's current symptoms are the result of a combination of the 1990 injury and claimant's preexisting degenerative disk disease. To prevail over SAIF's current condition and aggravation denial, claimant must, therefore, establish that the 1990 injury remains the major contributing cause of his current need for treatment. ORS 656.005(7)(a)(B).

There is no medical evidence supporting such a relationship. The medical experts have, instead, identified the degenerative disk disease as the major cause of claimant's current symptoms. (Exs. 4, 5, 12, 15, 21 and 22). Accordingly, claimant has not established a compensable relationship between the 1990 injury and his current neck and right arm symptoms.

ORDER

The Referee's order dated January 25, 1994 is reversed. The SAIF Corporation's October 28, 1993 denial is reinstated and upheld.

In the Matter of the Compensation of
MARTIN J. STUEHR, Claimant
WCB Case Nos. 93-08880 & 93-05570
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of that portion of Referee Podnar's order that set aside its denial of claimant's injury claim for a low back condition. Sedgwick James & Co. cross-requests review of that portion of the order that set aside its denial of claimant's occupational disease claim for the same condition. On review, the issues are compensability and responsibility. We reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction.

Dr. Stilson, not Dr. Ellison, released claimant from work from January 26 through February 11, 1993. (Ex. 3-2).

CONCLUSIONS OF LAW AND OPINION

Claimant began working at his custodial job for the Tigard School District (SAIF's insured) in August 1990, and at his job as a substitute bus driver for the Beaverton School District (whose claim was administered by Sedgwick James) in November 1991. Claimant worked concurrently at both jobs from November 1991 until January 26, 1993 when he was taken off work by Dr. Stilson due to low back complaints. On February 11, 1993, claimant returned to his custodial job. Claimant never successfully returned to his bus driving job although he made two unsuccessful attempts to return to that job in March 1993. Claimant continued to perform the custodial job and on May 17, 1993, fell while performing that work, triggering increased low back symptoms.

The Referee found that claimant's jobs together were the major contributing cause of his low back condition. Furthermore, under the "dual employment" rule, the Referee assigned responsibilty jointly to both employers. See Mary J. Joseph-Duby, 44 Van Natta 2272 (1992).

SAIF and Sedgwick James first assert that claimant failed to prove the compensability of his low back condition. Assuming compensability, SAIF contends that Sedgwick James is solely responsible. In reply, Sedgwick James argues that liability against it, if any, should be limited to treatment rendered before May 17, 1993 (the date on which, while performing his custodian activities for SAIF's insured, claimant fell and experienced increased low back symptoms).

Compensability

In January 1993, claimant sought treatment for low back and radiating left leg pain. These complaints began on January 15, 1993, while he was performing his bus driving activities. Claimant filed a workers' compensation claim in early February 1993 with Beaverton School District (Sedgwick James). (Ex. 1). In February 1993, claimant began experiencing right radicular leg pain and eventually was diagnosed with a herniated disc. On May 17, 1993, claimant slipped and fell while working as a custodian and suffered increased low back symptoms on the right. Claimant subsequently filed a workers' compensation claim with SAIF for this injury. (Ex. 18).

Several physicians offer opinions concerning the cause of claimant's low back condition. Dr. Moller, orthopedist, first treated claimant on February 24, 1993. Dr. Moller believed that claimant was suffering from a strain or overuse pattern that aggravated a preexisting underlying degenerative disc and lumbar condition. (Ex. 11). Moller opined that claimant's work as a bus driver caused a left-sided symptomatic aggravation of the preexisting degenerative condition, which subsided in a few weeks. Dr. Moller did not believe that claimant's right-sided symptoms and L3-4 disc herniation were related to his work as a bus driver.

Dr. Ellison began treating claimant for the low back condition in February 1993. He first opined that claimant's work as a bus driver aggravated his preexisting degenerative disc disease and resulted in left-sided symptoms which resolved by the first part of February 1993. Later, without explanation for this apparent change of opinion, Dr. Ellison stated that claimant's preexisting degenerative disc disease combined with his employment exposure both as a custodian and as a bus driver to produce his need for medical care and disability before his May 1993 fall.

Dr. Ellison also opined that claimant's May 17, 1993 fall produced a worsening of his condition which led to his eventual lumbar surgery. On this basis, Dr. Ellison opined that the major contributing cause of claimant's condition after May 17, 1993 was the fall at work on that date. In light of his unexplained change of opinion regarding the cause of claimant's condition before May 17, 1993, we find Dr. Ellison's opinion unpersuasive. See Kelso v. City of Salem, 87 Or App 630 (1987); Moe v. Ceiling Systems, 44 Or App 429 (1988).

Examining physicians Dinneen and Barth opined that the major contributing cause of claimant's disc herniation at L3-4 was presumed to be spontaneous and degenerative.

Dr. Wilson, an examining neurologist, opined that claimant's school bus driving did not cause claimant's ruptured disc at L3-4 or his right-sided back symptoms. He opined that claimant's symptoms of no right knee jerk and pain, weakness and numbness of the right leg were evidence of a compromise of a nerve root at the L3-4 level. Dr. Wilson agreed with Drs. Dinneen and Barth that the major contributing cause of claimant's L3-4 disc herniation was his preexisting degenerative disc disease.

Dr. Mason, a neurosurgeon, performed claimant's August 16, 1993 low back surgery. Dr. Mason diagnosed claimant's condition as disc herniations at L3-4 and L4-5. Dr. Mason concluded that claimant's work as a bus driver, as opposed to his May 17, 1993 fall while working as a custodian, was the primary cause of the conditions which ultimately resulted in the need for lumbar surgery. Specifically, Dr. Mason opined that claimant's work as a bus driver was the primary cause of his increasing discomfort and disability which ultimately resulted in the need for hospitalization and surgery.

After reviewing each of the aforementioned opinions, we are most persuaded by Dr. Mason's medical opinion. As the physician who performed claimant's lumbar surgery, Dr. Mason was in the best position to provide an opinion regarding the cause of claimant's low back condition. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Thus, we are persuaded by his opinion that claimant's bus driving activities constituted the major contributing cause of claimant's low back condition and resultant surgery.

SAIF argues that Dr. Mason failed to fully explain the role of claimant's degenerative disc disease. On this basis, SAIF contends that Dr. Mason's causation opinion is unpersuasive. We disagree. Dr. Mason explicitly disagreed with Dr. Wilson's theory that claimant's disc herniation was spontaneous and caused by degeneration. Dr. Mason explained that, although claimant had degenerative joint changes, he had no soft disc herniation and thus did not have a spontaneous herniation. Instead, Dr. Mason attributed the condition requiring surgery to claimant's bus driving activities. Thus, we find Dr. Mason's opinion regarding the role of the degenerative condition to be sufficiently explained.

Although he was aware that claimant had preexisting degenerative disc disease in his lumbar spine, Dr. Mason did not explicitly state that claimant's preexisting low back condition was pathologically worsened by his bus driving activities. See ORS 656.802(2). However, no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991).

After reviewing the totality of his opinion, we hold that Dr. Mason's conclusion that claimant's bus driving activities were the primary cause of the conditions which resulted in claimant's need for surgery, is sufficient to establish that claimant's work activities were the major contributing cause of a worsening of claimant's preexisting condition resulting in the need for surgery. Accordingly, claimant has established compensability of his low back condition as an occupational disease.

Responsibility

As previously noted, the Referee found both carrier's jointly responsible for claimant's condition under the "dual employment" rule. We find it unneccessary to rely on the concurrent employment rule because we conclude that claimant has established, based on Dr. Mason's opinion, that the major contributing cause of his low back condition was his work as a bus driver.

Where actual causation with respect to a specific identifiable employer is proven, it is not necessary to rely on judicially created rules of assignment pertaining to successive or concurrent employments in determining responsibility. See Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-245 (1984); Bracke v. Baza'r, 293 Or 239, 249-250; Eva R. Billings, 45 Van Natta 2142, 2143 (1993). Here, because actual causation was established against a particular employer, the "concurrent employment" rule does not apply. See Eva R. Billings, supra.

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

We have previously held that ORS 656.308(1) does not apply to determine the initial assignment of responsibility for a condition which has not been found compensable as to a particular employer. See Fred A. Nutter, 44 Van Natta 854 (1992). We specifically held in Nutter that ORS 656.308(1) did not alter the application of the last injurious exposure rule. However, whereas the last injurious exposure rule assigns initial responsibility for a condition between successive employers/insurers, ORS 656.308(1) applies to shift responsibility only after it has been determined that the condition is compensable as to a particular employer/insurer. See Gloria C. Garcia, 45 Van Natta 1702, 1703, n. 1 (1993). In Garcia, we held that ORS 656.308 expressly applies to "compensable" conditions (i.e., conditions related to the compensable injury) and is not limited to "accepted" conditions.

Here, we have found claimant's low back condition compensable as to Sedgwick James. Thus, ORS 656.308(1) applies to this case in order to determine whether responsibility for claimant's "post-May 17, 1993" low back condition shifts to SAIF. Id. We emphasize that claimant first filed a claim with Sedgwick James prior to the fall at SAIF's insured. Thus, having already determined that claimant's first claim with Sedgwick James is compensable, we then apply ORS 656.308(1) to determine whether responsibility shifts to SAIF as a result of the second claim (the fall at SAIF's insured).

Applying ORS 656.308(1), Sedgwick James remains responsible for future medical services and disability relating to the low back condition unless claimant sustains a new compensable injury involving the same condition. In SAIF v. Drews, 318 Or 1 (1993), the Court held that ORS 656.005(7)(a)(B) applies in the responsibility context to determine whether or not a worker sustained a "new compensable injury" under ORS 656.308. The Court reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior carrier is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer only if the injury is "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the major contributing cause, responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

Sedgwick James argues that its liability should be limited only to claimant's left-sided low back and leg symptoms in January and February 1993. However, Dr. Mason, the physician whose opinion we find most persuasive, does not distinguish between the left and right-sided symptoms. Rather, he attributes claimant's entire low back condition primarily to claimant's bus driving activities, as opposed to claimant's May 17, 1993 fall while working as a custodian. Based on Dr. Mason's persuasive opinion, we conclude that the May 17, 1993 injury at SAIF's insured was not the major contributing cause of claimant's disability and need for treatment for his low back.

Therefore, based on this record, we conclude that claimant did not sustain a "new compensable injury" at SAIF's insured. Id. Accordingly, responsibility for claimant's low back condition remains with Sedgwick James.

In summary, after conducting our review, we conclude that claimant's low back condition is compensable and that Sedgwick James, on behalf of the self-insured, is solely responsible for that condition. Consequently, we reverse those portions of the Referee's order that: (1) found both carriers jointly responsible for claimant's low back condition; (2) set aside SAIF's denial; and (3) found both carrier's jointly responsible for claimant's $3,000 attorney fee award.

Claimant's attorney is entitled to an assessed attorney fee for prevailing against Sedgwick James' cross-request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Sedgwick James. In reaching this conclusion, we have considered the complexity of the issues, the time devoted to the issues (as represented by claimant's cross-respondent's brief), and the value of the interests involved.

ORDER

The Referee's order dated November 17, 1993 is reversed in part and affirmed in part. SAIF's denial is reinstated and upheld. Sedgwick James & Co. shall pay the entire $3,000 attorney fee awarded by the Referee for claimant's counsel's services at hearing. For services on review, claimant's attorney is awarded $1,000 payable by Sedgwick James & Co. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
SHARON A. GAMBREL, Claimant
WCB Case No. 93-12848
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of that portion of Referee Nichols' order that awarded temporary total disability. On review, the issue is temporary total disability. We affirm.

FINDINGS OF FACT

Claimant was originally injured on December 10, 1987, when she fell while working for a mobile home manufacturer. Claimant's job duties included drywall installation and painting, and at the time of her injury, she was involved with cleaning the homes prior to their delivery. (Ex. 15). Claimant was examined by Dr. Coulter, who diagnosed a contusion and muscular strain/sprain. (Ex. 1).

An MRI performed in April 1988 showed evidence of a herniated disk at C4-5. Dr. Newby, a neurosurgeon, performed surgery on May 25, 1988. In December 1988, complaining of chronic, severe, incapacitating pain, claimant was referred to Dr. Dimitman, a psychiatrist. (Ex. 11).

In January 1989 claimant went through a "return to work" program at the Northwest Pain Center. It was determined that claimant could not return to her regular job. (Ex. 15). One of the January 1989 Northwest Pain Center reports indicated that claimant would not improve to any significant degree physically until she dealt with her psychological issues. (Ex. 14).

In February 1989 Dr. Newby reported that claimant was medically stationary and could reenter the work force in some type of clerical position. (Ex. 17). In April 1989, through vocational assistance, claimant was hired by another employer to work four hours per day as an office assistant/sales person. Claimant was expected to gradually increase her work hours to full time.

Claimant continued to complain of symptoms in her neck, arms and shoulders. She was receiving treatment from Dr. Newby, as well as physical therapy, osteopathic manipulation from Dr. Mann, psychiatric treatment from Dr. Dimitman and treatment from an acupuncturist for her headaches. (Ex. 30). While on her reduced work schedule, claimant received temporary partial disability (TPD) payments beginning April 1989. (Tr. 9).

An August 29, 1990 report from the Northwest Pain Center stated that claimant was medically and psychologically stationary without any evidence of permanent impairment from her December 1987 injury. (Ex. 29). The report indicated that claimant's work hours could be increased to 8 hours a day over the next month.

On October 10, 1990, Dr. Dimitman expressed his disagreement with the August 29, 1990 Northwest Pain Center report and stated claimant was not psychologically stationary, although she was making improvement. (Ex. 32). Dr. Newby reported that he thought it was feasible to increase to an 8 hour day over three to six months, rather than one month. (Ex. 31). In February 1991, Dr. Newby reported that claimant remained medically stationary, but recommended that claimant continue seeing Dr. Dimitman. (Ex. 36).

In March 1991, Dr. Newby reported that claimant was working 5 hours per day. (Ex. 37). Dr. Newby reported in April 1991 that claimant was "slowly getting worse as we have tapered her off of her various modalities with regard to her neck and low back pain." (Ex. 39). The insurer terminated claimant's TPD in April 1991 because the two year period under ORS 656.212 had expired. (Tr. 9).

In September 1991, Dr. Newby noted that claimant planned to take a leave of absence from January to March 1992 to see if that would improve her symptoms. (Ex. 42). In November 1991, the vocational consultant reported that claimant preferred to remain at 4 hours per day, although her employer had offered her a full-time position. (Exs. 44 & 45). Claimant's return to work assistance ended.

Dr. Holland performed a psychiatric examination for the insurer in November 1991 and agreed with the Northwest Pain Center's conclusion that it was unlikely claimant would ever return to full vocational productivity until her psychological problems were resolved. (Ex. 46). Dr. Holland concluded that claimant's somatoform pain disorder remained the primary impediment to her working full-time and the disorder did not allow any objective rating of impairment. (Id.) Dr. Holland also concluded that claimant was psychiatrically stationary from any effects due to the industrial injury. Drs. Newby and Mann concurred in Dr. Holland's report, but Dr. Dimitman disagreed with Dr. Holland's conclusions.

In March 1993, Dr. Newby reported that claimant's headaches and shoulder pain were exacerbated by her work and he cut her hours to half-time for one month. (Ex. 56). According to Dr. Dimitman's chart notes, claimant's employer refused to let her work half-time. (Ex. 56c).

In June 1993, the employer notified claimant that she would be terminated because she had been missing work and making mistakes due to her pain. (Tr. 13-14; Ex. 59a). Claimant's manager testified that he no longer had a part-time position available because business had doubled. (Tr. 17-18). Claimant worked through July 1993. On July 29, 1993, Dr. Newby notified the insurer that claimant "recently had to stop work because of ongoing pain and discomfort and inability to perform her job." (Ex. 64). The insurer did not reinstate claimant's temporary total disability (TTD).

Dr. Newby's September 9, 1993 chart notes indicate that claimant continued to struggle with chronic neck pain but continued to improve. (Ex. 66). Dr. Mann notified the insurer on September 27, 1993 that he had not authorized time loss for claimant. (Ex. 67). On October 14, 1993, the insurer issued a partial denial of claimant's request for temporary disability. (Ex. 69).

On October 27, 1993, Dr. Dimitman reported that claimant continued to make progress in her psychiatric condition, although he did not believe she was capable of working full-time. (Ex. 70). On November 18, 1993, Dr. Newby reported that claimant's neck pain had subsided considerably and she was medically stationary. (Ex. 71). He said she could return to work without any repetitive lifting over 20 pounds. On December 29, 1993, Dr. Newby notified claimant's attorney that he had not authorized any time loss for claimant. (Ex. 76).

In January 1994, Dr. Newby agreed, in a "check-the-box" letter to claimant's attorney, that in summer 1993 claimant was at least partially disabled from performing the work activities in the job in which she sustained her injury. He also agreed that she has permanent disability that prevents her performing at least some of those work activities. (Ex. 78).

Claimant has not worked since July 1993, although she has looked for work with other employers. Her claim has never been closed. Claimant has never been released to return to her job at injury, although she has been released to return to modified work. At the hearing, the insurer stated that it had never accepted claimant's psychological condition.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant TTD from the date her modified job was withdrawn. Relying on EBI Ins. Co. v. Witt, 113 Or App 7 (1992), the insurer contends that claimant is not entitled to further temporary disability payments because her disability is not "temporary" and is not reasonably expected to change. In Ralph L. Witt, 42 Van Natta 2628 (1990), the Board awarded the claimant TPD beyond the two-year period provided under ORS 656.212, reasoning that claimant had two unconsecutive periods of TPD. The Court of Appeals reversed and concluded that ORS 656.212 did not apply because the record did not support a conclusion that claimant's disability was "temporary in character." EBI Ins. Co. v. Witt, supra, 113 Or App at 11.

In the present case, the insurer's reliance on Witt is misplaced. In EBI Ins. Co. v. Witt, supra, the court stated that "[t]he parties agree that claimant is disabled and that he is not expected ever to recover fully from being disabled." Id. at 10. In fact, there was no evidence that the claimant in Witt was ever expected to become less disabled or recover from his disease. Id. at 11. Unlike in Witt, the parties in this case have not agreed on whether claimant's disability is "temporary in character" and

whether claimant is ever expected to become less disabled.[1] Therefore, we conclude that EBI Ins. Co. v. Witt, supra, does not apply to this case.

The insurer was originally authorized to terminate claimant's TTD benefits pursuant to ORS 656.268(3)(a) when claimant returned to modified work for her new employer. At that time claimant became eligible for TPD. ORS 656.212 provides that when the disability is or becomes partial only and is temporary in character, the worker shall receive TPD benefits "for a period not exceeding two years." See also former OAR 436-60-030(4)(d). Claimant received TPD from April 1989 until April 1991. The insurer was authorized under ORS 656.212 to terminate claimant's TPD benefits after April 1991.

Claimant does not argue that she is entitled to further temporary partial disability benefits. Rather, she seeks temporary total disability benefits because her modified job offer was withdrawn. The Referee relied on OAR 436-60-030(4)(b) in awarding claimant TTD. Former OAR 436-60-030(4)(b) (WCD Admin. Order 12-1992) provided, in part:

> "Temporary partial disability compensation paid under section (3) shall continue until: * * *
>
> "(b) The job no longer exists or the job offer is withdrawn. This includes but is not limited to termination of temporary employment, layoff or plant closure. The worker is entitled to temporary total disability compensation as of the date the job no longer is available. Discharging the worker for violation of normal employment standards is not withdrawal of a job offer." (Emphasis added).

The underlying premise of former OAR 436-60-030(4)(b) is that the worker must be currently receiving TPD. Claimant was no longer receiving those benefits in July 1993 and she does not contend that the insurer wrongfully terminated those benefits after the two-year period expired in April 1991. Therefore, former OAR 436-60-030(4)(b) does not apply in this case.

Notwithstanding the inapplicability of the aforementioned rule, we continue to find that claimant is entitled to TTD. Claimant's claim is still open and she has neither returned nor has she been released to regular work. Although the insurer was authorized to terminate claimant's TTD benefits pursuant to ORS 656.268(3)(a) when claimant returned to modified work for her employer, that circumstance no longer existed in July 1993 when the employer effectively withdrew its modified work offer.

The record reflects that Dr. Newby reduced claimant's hours to half-time for one month in March 1993 because of her pain complaints, but the employer did not allow the reduction. In June 1993, the employer notified claimant that she would be terminated. Claimant testified that she quit working as a result of a mutual decision with her employer that she was physically unable to perform the duties of her job on a full-time basis. (Tr. 25-26; Ex. 72). Claimant's manager testified that he did not have any part-time positions available any longer because business had doubled. (Tr. 17-18). Because

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[1] The insurer contends that claimant's disability is not reasonably expected to change, but it offers no explanation why her claim remains open. Although there is at least some evidence that claimant may have a permanent disability, the record is not clear on that point.

In March 1993, Dr. Newby reduced claimant's hours to half-time for one month because of her pain complaints. (Ex. 56). According to Dr. Dimitman's chart notes, claimant's employer refused to let her work half-time. (Ex. 56c). In June 1993, the employer notified claimant that she would be terminated because she had been missing work and making mistakes due to her pain. (Tr. 13-14; Ex. 59a). Claimant worked through July 1993.

On November 18, 1993, Dr. Newby reported that claimant was medically stationary and her "motor exam and reflex exam in both upper extremities are quite normal." (Ex. 71). He said claimant could return to work without any repetitive lifting over 20 pounds. In January 1994, Dr. Newby agreed, in a "check-the-box" letter to claimant's attorney, that claimant had permanent disability that prevented her performing at least some of the work activities in the job in which she sustained her injury. (Ex. 78). In the same letter, however, Dr. Newby agreed that when claimant's employment ended in the summer of 1993, she was "at least partially disabled" from performing those job activities. In light of Dr. Newby's subsequent statement specifically addressing permanent disability, we construe Dr. Newby's prior statement to mean that claimant was temporarily disabled in the summer of 1993. Under these circumstances, we conclude that it is not clear whether claimant's disability is temporary or whether she is expected to become less disabled. In making this determination, we emphasize that the parties have not asked us to decide any other issues involving claims processing.

claimant was unable to perform even modified work when her modified job was withdrawn, the employer at injury was required to reinstitute the payment of TTD. See Gray v. SAIF, 70 Or App 313 (1984); Marcheta M. West, 46 Van Natta 402 (1994); Carmen Gusman, 42 Van Natta 425 (1990).

A worker whose temporary disability benefits have been properly terminated becomes entitled to resumption of TTD payments if, prior to claim closure, the attending physician again authorizes time loss. See OAR 436-30-036(1); Rodgers v. Weyerhaeuser Company, 88 Or App 458 (1987); Robert D. Gudge, 42 Van Natta 812 (1990). Claimant's modified job was terminated because she had been missing work and making mistakes due to the pain from her industrial injury. (Tr. 13-14; Ex. 59a). On July 29, 1993, Dr. Newby notified the insurer that claimant was no longer working at her modified job. Dr. Newby confirmed that claimant was unable to work, reporting that she "recently had to stop work because of ongoing pain and discomfort and inability to perform her job." (Ex. 64). Dr. Newby also stated that claimant was "very frustrated in that she wants to continue working, but her pain limits what she can do." (Id.) We construe Dr. Newby's July 29, 1993 letter as notification requiring the insurer to reinstate the payment of TTD. Although Dr. Newby's July 29, 1993 letter did not expressly authorize time loss for claimant, the letter clearly documented claimant's inability to continue working as a result of her ongoing pain complaints.

In a December 29, 1993 letter to claimant's attorney, Dr. Newby acknowledged that he had not authorized any time loss for claimant. (Ex. 76). In January 1994, however, Dr. Newby agreed that in the summer of 1993 claimant was at least partially disabled from performing the work activities in the job in which she sustained her injury. (Ex. 78). We construe the subsequent letter as a clarification of the December 29, 1993 letter and we conclude that claimant was unable to perform her work activities when she left her employment in July 1993.

The insurer does not argue that it was authorized to suspend temporary disability benefits pursuant to ORS 656.262(4)(b) because it failed to receive verification of an inability to work. See Sandoval v. Crystal Pine, 118 Or App 640, rev den 317 Or 272 (1993). We find no evidence that the insurer requested such verification from Dr. Newby.[2]

Under these circumstances, we conclude that claimant is entitled to reinstatement of TTD when her modified job was withdrawn until termination is authorized by law.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 16, 1994 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the insurer.

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[2] The record indicates that the insurer sought verification from Dr. Mann, an osteopathic physician. (Ex. 67). We note that a November 1991 IME report indicated that claimant had initiated a change of attending physician statement showing Dr. Mann as her treating physician. (Ex. 46). The attending physician statement, however, is not part of the record and the insurer does not argue that Dr. Mann is claimant's attending physician. Thus, we find that the insurer's attempt to verify claimant's inability to work with Dr. Mann did not satisfy the requirements of ORS 656.262(4)(b).

In any event, we find that Dr. Newby is claimant's attending physician. ORS 656.005(12)(b) defines an "attending physician" as "a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury." Dr. Newby performed an anterior cervical diskectomy on claimant on May 25, 1988 and has been treating claimant for her neck condition since that time. Claimant also testified that Dr. Newby was the primary doctor for her neck condition. (Tr. 28). Inasmuch as the determination of an "attending physician" is a question of fact, this record establishes that Dr. Newby satisfied that description. See Paula J. Gilman, 44 Van Natta 2539 (1992).

In the Matter of the Compensation of
GLORIA E. HEATH, Claimant
WCB Case No. 93-06658
ORDER ON REVIEW
Peter J. Carini, Claimant Attorney
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Black's order that upheld the SAIF Corporation's denial of claimant's injury/occupational disease claim for a cervical condition. In addition, claimant moves the Board for an order remanding the case to the Referee for the admission of additional evidence. On review, the issues are remand and compensability. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the finding that four or five patients required lifting. Based on claimant's testimony, we find instead that six to ten of her patients required lifting multiple times each day.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant contends that the Referee erred in refusing to admit into evidence proposed Exhibit 21, a September 2, 1993 medical report from Dr. Golden. Claimant did not receive Dr. Golden's report, addressed to a claims examiner at SAIF, until September 15, 1993, after the hearing on September 9, 1993. SAIF's copy of Dr. Golden's report was not date-stamped until September 17, 1993. There is no explanation why claimant ostensibly received a copy of Dr. Golden's report before SAIF, even though the report was addressed to SAIF with no carbon copy to claimant's attorney.

In any event, after receiving the report, claimant moved that the record be reopened to admit Dr. Golden's report, which contains his comments regarding an August 26, 1993 medical report from examining physicians Drs. Barth and Potter, who evaluated claimant's cervical condition on behalf of SAIF. The Referee sustained SAIF's objection to admitting the report on the grounds that it was not new, previously undiscoverable evidence within the meaning of OAR 438-07-025. The Referee noted that Dr. Golden's report was a late medical report from a physician whose medical reports were already in evidence.

We may remand a case to the Referee for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the referee. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988). However, before we address claimant's remand motion, we first respond to claimant's contention that the Referee erred in declining to admit Dr. Golden's medical report.

ORS 656.283(7) sets the standards by which evidence is admitted in workers' compensation hearings. The statute specifies that the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7). Referees have broad discretion when rendering procedural and evidentiary rulings. Lyle A. McManus, 43 Van Natta 863 (1991). OAR 438-07-025(2) provides that the party moving for consideration of new material evidence must provide an explanation why such evidence could not have been discovered and produced at the hearing. Renia Broyles, 42 Van Natta 1203 (1990).

Claimant contends that Dr. Golden's report could not have been reasonably discovered and produced at hearing because she was unaware of the report due to SAIF's failure to produce the letter requesting Dr. Golden's response to the report of SAIF's examining physicians. We reject claimant's argument.

Although claimant could not have reasonably produced a medical report of which she was not aware, Dr. Golden had already provided a report explaining his medical opinion that was admitted into the record at the hearing. (Ex. 17). We recognize that Dr. Golden's response to the examining physicians' report contained information not contained in his earlier report. However, claimant received the Barth/Potter report on September 1, 1993, prior to the September 9, 1993 hearing. Thus, claimant could have provided Dr. Golden with a copy prior to the hearing and obtained a report very similar to what SAIF received. However, claimant did not obtain a report or request that the record be left open for rebuttal evidence. Therefore, while Dr. Golden's September 2, 1993 medical report was not available on the date of the hearing, the substance of that opinion was discoverable prior to the closing of the record. We, therefore, conclude that the Referee did not abuse his discretion in not admitting Dr. Golden's September 2, 1993 report.[1]

With regard to claimant's motion for remand, we are convinced that the substance of Dr. Golden's September 2, 1992 medical report was obtainable with due diligence at the time of the hearing. Moreover, in light of the persuasive opinion of Dr. Woolpert, SAIF's examining physician, as supported by Dr. Jansen, who conducted a records review for SAIF, and the examining physicians, Drs. Barth and Potter, we are not convinced that admission of Exhibit 21 would reasonably affect the outcome of the case. See Compton v. Weyerhaeuser Co., supra. Therefore, we deny claimant's request for remand.

Finally, claimant requests that we remand the case to the Referee to determine whether SAIF committed a discovery violation in failing to provide her with a copy of SAIF's letter to Dr. Golden. To the extent that claimant is requesting that we remand for admission of SAIF's letter, we find no compelling basis to do so. This letter is unlikely to affect the outcome of the case. Compton v. Weyerhaeuser, supra. Moreover, to the extent that claimant is alleging that a discovery violation has occurred, thereby entitling her to a penalty or attorney fee, we will not consider this issue for the first time on appeal. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

Compensability

Claimant, a certified nursing assistant, performed her usual work activities without incident on March 18, 1993. She went home after her shift with the normal amount of aches and pains in her neck, back and shoulder. When she awoke from a 45-minute nap, her legs felt numb and tingly. Claimant's discomfort continued and she sought medical treatment two days later. Dr. Golden subsequently diagnosed a C5-6 disc herniation for which he performed surgical repair. Extreme degeneration of the disc was noted at surgery.

Claimant filed a claim for workers' compensation benefits. The Referee concluded that claimant failed to sustain her burden of proving that her cervical condition was compensable. Specifically, the Referee found that claimant had failed to prove compensability on either an accidental injury or occupational disease theory. In so doing, the Referee found the opinions of Drs. Woolpert, Jansen, Barth and Potter more persuasive than those of Dr. Golden or Dr. Mundall, a consulting neurologist. On review, claimant contends that the Referee erred in his assessment of the medical evidence. We disagree.

On July 22, 1993, a legal assistant from claimant's counsel's office wrote a letter to Dr. Golden, requesting his opinion on the causation of claimant's herniated cervical disc. (Ex. 16). In this letter, Dr. Golden was advised that claimant was generally placed in "heavy units" at her place of employment which involved the lifting of heavy patients, mostly males. Dr. Golden was also advised that patients would "lock" their arms around claimant's neck while she would lift them, thereby placing most of the patient's weight around claimant's neck and shoulders.

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[1] Although we do not find an abuse of the Referee's discretion in this case, our finding should not be construed as approval of SAIF's conduct in failing to disclose that a medical report would be forthcoming from Dr. Golden. While SAIF's counsel may not have been personally aware that the claims examiner had solicited a medical report, we consider SAIF's counsel to have had constructive knowledge that a report had been requested. Cf. Nix v. SAIF, 80 Or App 656 (1986) (employer knowledge legally attributable to insurer). Therefore, counsel had a duty to reveal that a report had been solicited and would likely be forthcoming. Since it is readily apparent from Dr. Golden's response that SAIF had requested his September 2, 1993 opinion, we do not agree with the Referee that the report "came out of nowhere."

Dr. Golden subsequently wrote a letter to SAIF on August 9, 1993, with a copy to claimant's counsel, explaining his opinion concerning the causation of claimant's herniated disc. In his letter, Dr. Golden concluded that, based on a history that claimant performed heavier than average work and lifted more than the usual number of patients on March 18, 1993, claimant sustained an injury at work. (Ex. 17-2).

In response to an identical letter from claimant's counsel's office, Dr. Mundall concluded that claimant's work activities were the major contributing cause of her herniated cervical disc. (Ex. 19). Dr. Mundall stated that a large disc herniation, such as what claimant experienced, was usually related to an injury as opposed to occurring spontaneously. Moreover, Dr. Mundall explained that frequent lifting of patients in awkward positions "could be conceived" as causing increased venous pressure that was transmitted to the cervical disc, leading to the disc herniation. Dr. Mundall's letter was addressed to claimant's counsel's office.

Given the presence of a preexisting degenerative condition, as well as the fact that symptoms of claimant's herniated disc occurred after work and not in connection with a specific work incident, we find that the medical causation issue is complex, thereby requiring expert medical evidence for its resolution. See Uris v. Compensation Department, 247 Or 420 (1967). Absent persuasive reasons to do otherwise, we generally give greater weight to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810, 814 (1983). Like the Referee, however, we believe that this claim involves expert analysis rather than expert observation. Therefore, the attending physician's opinion is not entitled to special deference. Allie v. SAIF, 79 Or App 284 (1986). Moreover, even assuming this claim involved expert observation, we would still find persuasive reasons to discount the medical evidence from the treating physician, Dr. Golden.

First, the information provided to Dr. Golden by claimant's counsel was not confirmed by claimant's testimony. Claimant did not testify that she was assigned to an unusually heavy unit on March 18, 1993. Moreover, she did not testify that patients were segregated according to gender or personal characteristics such as weight. (Tr. 5). In addition, claimant never testified that patients would "lock" their arms around claimant's neck. More importantly, claimant testified that 75 percent of her lifts were accomplished with the assistance of a device called a "gait belt" that relieved pressure on the neck. (Tr. 19, 23). There is no indication that Dr. Golden or Dr. Mundall was aware of claimant's use of this device. Although it is not clear that Dr. Golden's August 9, 1993 report was influenced by the letter from claimant's counsel's office, to the extent that Dr. Golden relied on the history contained in that letter, his August 9, 1993 medical opinion was based on incomplete information and inaccurate assumptions.

Second, even if Dr. Golden did not base his August 9, 1993 opinion on the inaccurate and incomplete history in the July 22, 1993 letter from claimant's counsel's office, his August 9, 1993 medical report is still based on an inaccurate history of unusually heavy work on March 18, 1993. Claimant testified that her work activities that day were no different from her typical duties. (Tr. 9). Therefore, claimant never testified that her work load on March 18, 1993 was heavier or more demanding than normal. Inasmuch as Dr. Golden's medical opinion was based on erroneous and incomplete information, we find persuasive reasons to discount its value. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Similar concerns also require that we discount Dr. Mundall's opinion. As previously noted, Dr. Mundall was also provided with the same inaccurate and incomplete history that Dr. Golden received. In addition, Dr. Mundall's opinion was couched in terms of medical possibility rather than probability. Accordingly, we find that is deficient in that respect as well. See Gormley v. SAIF, 52 Or App 1055 (1981).

In contrast to the flawed medical opinions of Dr. Golden and Dr. Mundall, Dr. Woolpert's medical opinion, as expressed in his June 7, 1993 report, is well-reasoned and persuasive. (Ex. 13). Dr. Woolpert explained that, because claimant's cervical disc herniated without specific trauma, this indicated that claimant's degenerative disc disease had progressed to the point where it could herniate with little or no provocation. Dr. Woolpert further explained that, since there was no specific incident of trauma at work, claimant could just have easily herniated the disc as a result of sleeping in an awkward position or engaging in some other innocuous activity. Given the history of the onset of claimant's herniated disc, Dr. Woolpert could not conclude that it was even materially related to claimant's employment activities.

Dr. Woolpert's opinion is supported by Dr. Jansen, who conducted a records review for SAIF and concurred with Dr. Woolpert's opinion. (Ex. 15). The Barth/Potter panel also concurred with Dr. Woolpert's opinion. (Ex. 20). They could not relate claimant's herniated cervical disc either in material or major part to claimant's work activities. The panel did confirm that the major factor in claimant's cervical condition was the preexisting degenerative disc disease.

Based on our de novo review of the medical evidence and claimant's testimony, we agree with the Referee that claimant failed to sustain her burden of proving that she sustained either a compensable industrial injury or occupational disease.[2] The Referee properly upheld SAIF's denial.

ORDER

The Referee's order dated January 19, 1994 is affirmed.

[2] We agree with claimant that a specific traumatic incident or unusual exertion is not required to establish a compensable claim. See Hubble v. SAIF, 56 Or App 154 rev den 293 Or 103 (1982); Batdorf v. SAIF, 54 Or App 496 (1981). Our decision is based on the lack of persuasive medical evidence linking claimant's work activity on March 18, 1993 to her cervical disc herniation.

In the Matter of the Compensation of
JERILYN HENDRICKSON, Claimant
WCB Case No. 93-13177
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Lipton's order that: (1) set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS); (2) awarded claimant interim compensation; (3) assessed a penalty for the employer's allegedly unreasonable failure to pay interim compensation; and (4) assessed a penalty for the employer's late denial. On review, the issues are compensability, interim compensation, and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact. In addition, we offer the following supplementation and summary of the pertinent facts.

Claimant began working for the employer on June 21, 1993. She was assigned to sand truck hoods in the cab shop in preparation for painting. After working for the employer for several weeks, claimant was occasionally assigned to fill-in on the chassis line "masking" truck chassis. After working for the employer for a month and a half, claimant became a full-time painter's helper, masking trucks on the chassis line.

Claimant masked 30 to 50 parts on 28 trucks each shift (840 to 1440 parts). Within one week of masking full-time, claimant began to experience right hand numbness at night. By August 23, claimant was experiencing hand pain for which she sought treatment from the employer's nurse. The nurse gave claimant pain medication and a brace, and referred claimant to Dr. Campbell. Claimant continued to work on the chassis line.

Dr. Campbell released claimant to modified work on September 3, 1993. Specifically, Dr. Campbell recommended that claimant perform limited work with her dominant right hand, and no forceful gripping. After initially being directed to perform her regular job duties on September 3, 1993, claimant was eventually assigned to sand in the cab shop. Midway through the September 3, 1993 shift, the employer terminated claimant for illness-related absences on June 25 and August 12, 1993.

On January 6, 1994, Dr. Ushman, claimant's treating physician, continued claimant on modified work. Dr. Ushman recommended that claimant perform no work requiring repetitive gripping or bending of the right wrist, or more than minimal use of the right hand.

The employer received claimant's wrist claim on September 2, 1993. It issued a denial on January 20, 1994. Pending issuance of its denial, the employer did not pay interim compensation.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the Referee's opinion as it pertains to this issue, with the following comment.

On review, the employer urges the Board to rely on the opinion of its examiner, Dr. Radecki, rather than that of Dr. Ushman. The employer contends that Dr. Ushman's opinion is based on an inaccurate history. Specifically, it notes that Dr. Ushman was mistaken as to: claimant's hire date, whether the employer complied with Dr. Campbell's light duty work release, and the duration of claimant's work as a painter's helper.

We do not find that the "inaccuracies" cited by the employer diminish the persuasiveness of Dr. Ushman's opinion. Dr. Ushman was apprised that claimant began working for the employer in June 1993, that her symptoms began after performing the masking job on a steady basis for one week and that, within two to three weeks, claimant's symptoms progressed to include pain and constant tingling and numbness, such that claimant sought care from the company nurse. This is consistent with claimant's testimony at hearing, and the facts upon which the employer relies.

Dr. Ushman correctly noted, as did examining physician Radecki, that claimant had no previous history of hand or wrist problems, and that claimant's condition occurred after performing masking duties as a painter's helper. Dr. Ushman concluded, therefore, that repetitive tearing, wrapping and pinching activities were the major contributing cause of claimant's right CTS.

On the other hand, Dr. Radecki believes that body build is more significant than any work exposure. Dr. Radecki cites studies by Dr. Nathan that indicate that personal characteristics, such as age and build, are more likely causes than are activities. In other words, Dr. Radecki opined that claimant fits the profile of a person likely to get CTS, regardless of her work. Therefore, Dr. Radecki opines that claimant's weight gain during two pregnancies in the past, during which claimant did not develop CTS, is the cause of claimant's current CTS, rather than the repetitive activity required to mask 840 to 1440 trucks parts each shift. Because Dr. Radecki relied on studies which do not involve claimant, we find his opinion concerning claimant to be insufficiently explained. As such, we find it not particularly persuasive. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). We further adopt and affirm the analysis and conclusions set forth by the Referee in the Opinion and Order (pgs. 3-5).

Interim Compensation

We adopt and affirm the Referee's opinion, which awarded claimant interim compensation, with the following supplementation.

The employer received claimant's wrist claim on September 2, 1993. It issued a denial on January 20, 1994. Pending the issuance of its denial, the employer did not pay interim compensation. In light of claimant's termination, the employer contends that claimant is not entitled to such benefits, because her wage at termination was the same as her wage at injury. See Stone v. Whittier Wood products, 116 Or App 427 (1992). The employer's reliance on Stone is misplaced. Stone concerned the rate at which a claimant's temporary partial disability is calculated. Moreover, on reconsideration, the court explained that an employer is required to determine a claimant's eligibility for temporary disability. Determining the amount of temporary disability is not the starting point in determining eligibility for temporary disability. Stone v. Whittier Wood products, 124 Or App 117, 122 (1993).

Instead, interim compensation is due beginning 14 days after the date upon which the employer or its insurer receives notice or knowledge of the claim. ORS 656.262(4). The purposes of interim compensation are to prevent processing delays and to assure a worker's well-being during the period in which acceptance or denial of a claim is being considered. Jones v. Emanuel Hospital, 280 Or 147 (1977).

A claimant who has been fired from work, but otherwise is in the work force, is entitled to interim compensation if the worker has "left work," i.e., either been absent from work or sustained diminished earning power, for such period as is attributable to work-related disability. Randel G. Jensen, 45 Van Natta 898 (1993), (citing Bono v. SAIF, 298 Or 405 (1984); Nix v. SAIF, 80 Or App 656, 659 (1986); and Weyerhauser Company v. Bergstrom, 77 Or App 425 (1986)), affirmed RSG Forest Products v. Jensen, 127 Or App 247 (1994).

Here, the work restrictions placed on claimant by Drs. Campbell and Ushman resulted in diminished earning power. See RSG Forest Products v. Jensen, supra, 127 Or App at 252. Moreover, when claimant filed her claim on September 2, 1993, she was in the work force. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 257 (1989); Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Randel G. Jensen, supra, 45 Van Natta at 900-01. Because claimant "left work" and suffered a loss of earnings related to her injury, the fact that the employer fired claimant for reasons unrelated to her injury does not preclude claimant from receiving interim compensation. RSG Forest Products v. Jensen, supra, 127 Or App at 252.

Consequently, because claimant "left work" as a result of her work activities with the employer, we find that claimant is entitled to the interim compensation granted by the Referee.

Penalties

Failure to Pay Interim Compensation

On review, the employer argues that the Referee should not have imposed a penalty based on the court's October 1993 decision in Stone v. Whittier Wood products, 124 Or App 117, where "the essential facts relative to claimant's termination and entitlement to time loss benefits occurred on September 3, 1993." We adopt and affirm the Referee's opinion that it was unreasonable for the employer not to have addressed claimant's entitlement to interim compensation at any time prior to its January 1994 denial. Further, as the Court has noted, ORS 656.262 gives the employer two choices: deny the claim or make interim payments. Jones v. Emanuel Hospital, supra at 151. The Stone court did not change existing caselaw as it pertains to interim compensation.

Late Denial

Finally, the employer argues that because claimant's claim is not compensable and claimant is not entitled to interim compensation, there are no amounts "then due" and, thus, no basis to impose a penalty for late denial. We have herein found to the contrary; i.e. we have affirmed the Referee's order finding the claim compensable. Accordingly, we adopt and affirm the Referee's reasoning and conclusion that a penalty should be assessed for the employer's unexplained failure to issue a denial within 90 days of notice or knowledge of the claim.

Claimant's attorney is entitled to a reasonable assessed fee for services on review concerning the compensability and interim compensation issues. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review regarding the compensability and interim compensation issues is $1,350, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and statement of services), the complexity of the issues, and the value of the interest involved.

Inasmuch as penalties are not considered compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to an attorney fee award for services on review concerning the Referee's penalty assessments. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The Referee's order dated February 17, 1994 is affirmed. Claimant's counsel is awarded $1,350 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
JOHN A. HOFFMEISTER, Claimant
WCB Case No. 93-00513
ORDER DENYING RECONSIDERATION
Olson Law Firm, Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

On August 25, 1994, Members Westerband and Haynes (with Member Gunn dissenting) reversed a Referee's order which had set aside the self-insured employer's denial of claimant's occupational disease claim for Hepatitis C exposure. Concluding that claimant had not established the compensability of his claim, Members Westerband and Haynes reinstated and upheld the employer's denial. Asserting that the reasoning contained in the majority's decision is flawed, claimant seeks reconsideration.

Effective September 18, 1994, Member Westerband has resigned his position as a member of the Board. Notwithstanding that resignation and despite any disagreements which we might have with particular decisions reached by him, we shall adhere to those decisions.

Accordingly, the motion for reconsideration is denied.[1]

IT IS SO ORDERED.

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[1] Member Gunn would note this is not the first time he has lost this argument in other cases. See Lynne C. Gibbons, 46 Van Natta 1698 (1994). To abate this case would only delay the parties with little improvement in the chances that the outcome will change. Delay by two to four months while we further struggle with this matter will not change the outcome or produce any newer insights and would only waste the parties' time -- better spent briefing and arguing at the Court of Appeals.

In the Matter of the Compensation of
DANA E. MURPHY, Claimant
WCB Case No. 93-11248
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the SAIF Corporation's denial of claimant's low back "consequential" condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable right knee injury claim. In April 1993, she underwent reconstructive surgery on the knee. Following surgery, claimant's treating physician prescribed physical therapy to rehabilitate the condition of the right knee. While participating in such activities, claimant experienced low back pain and received treatment.

The Referee upheld SAIF's denial of claimant's low back condition. Relying on Kephart v. Green River Lumber, 118 Or App 76, rev den 317 Or 272 (1993), and Hicks v. Spectra Physics, 117 Or App 293 (1992), the Referee determined that the low back condition was not a compensable consequence of the right knee injury under ORS 656.005(7)(a)(A) because the medical evidence showed that physical therapy activities, rather than the compensable injury, was the major contributing cause of the need for low back treatment and disability. Claimant challenges the Referee's finding, asserting that the Referee erroneously interpreted the statute and that injuries caused by treatment for a compensable condition are also compensable.

Following the Referee's order, the court construed ORS 656.005(7)(a)(A) in determining the compensability of an injury caused by physical therapy activities. Barrett Business Services v. Hames, 130 Or App 190 (1994). Relying in part on legislative history, the court in Hames found that the legislature did not intend to overrule prior caselaw finding compensable new injuries incurred during medical treatment for compensable injuries by the enacting ORS 656.005(7)(a)(A). Thus, the court construed the statute as establishing the compensability of a new injury if the major contributing cause is necessary and reasonable treatment of a compensable injury. Id. at ___ .

The facts in this case are not distinguishable from those in Hames. Furthermore, the medical evidence shows that physical therapy, which was prescribed to treat claimant's compensable knee injury, was the major contributing cause of her low back condition. (Ex. 10). Therefore, claimant proved the compensability of her low back condition. See Barrett Business Services v. Hames, supra; ORS 656.005(7)(a)(A).

Claimant's attorney is entitled to an assessed fee for finally prevailing over SAIF's denial. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $2,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the documentary record and arguments of counsel at hearing and claimant's appellant's brief on review), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated January 14, 1994 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by SAIF.

September 22, 1994 Cite as 46 Van Natta 1892 (1994)

In the Matter of the Compensation of
BONITA J. OLSON, Claimant
WCB Case Nos. 93-09491, 93-12319, 93-09490 & 93-12320
ORDER ON RECONSIDERATION
Welch, Bruun, et al., Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

The SAIF Corporation requests reconsideration of those portions of our August 31, 1994 Order on Review that determined that: (1) SAIF's October 13, 1993 denial denied the compensability of, as well as responsibility for, claimant's current condition; and (2) the May 10, 1993 work release notified the employer of claimant's claim and that notification was imputed to SAIF. SAIF contends that both determinations were wrongly decided. We disagree.

Regarding SAIF's argument that its October 13, 1993 denial did not include a denial of compensability, we conclude that our Order on Review adequately addresses that argument. SAIF argues that the instant case is distinguishable from Johnny M. Davis, 45 Van Natta 2282 (1993), and David J. Rowe, 46 Van Natta 1150 (1994), in that in those cases a .307 order either was not requested by the insurer or was not issued, whereas, here, SAIF requested a .307 order and one was issued. However, we find that this is a distinction without a difference. As we explained in our prior order, because the issuance of a .307 order does not preclude a carrier from subsequently denying compensability, we do not consider SAIF's request for designation of a paying agent to be conclusive evidence that SAIF was not contesting compensability of claimant's claim. For the reasons listed in our prior order, we continue to find that SAIF's October 13, 1993 denial included a compensability denial.

Turning to the notice issue, our order concluded that the May 10, 1993 work release notified the subject employer of claimant's claim, as required by statute, and that that notification was imputed to SAIF, the employer's current insurer. ORS 656.262(4)(a); 656.262(6). The work release also notified the employer that claimant's condition was work related.

On reconsideration, SAIF cites Hubert R. Graves, 46 Van Natta 1032 (1994), and David Hernandez, 46 Van Natta 423 (1994), in support of its argument that the May 10, 1993 work release was not sufficient notice of a claim in regards to SAIF because it did not contain notification of a "new injury," but was instead an "aggravation" claim. SAIF's "new injury" versus "aggravation" notification argument was adequately addressed in our prior order. In addition, we find the cases cited by SAIF on reconsideration to be distinguishable.

In Graves, supra, the Board found that no claim had been filed for a separate condition until the carrier received notice that the separate condition might be related to the work injury. However, here, the May 10, 1993 work release notified the employer that claimant's condition was work related.

In Hernandez, supra, the claimant sustained a compensable back injury with an earlier employer before he began working for a subsequent employer. While employed by the subsequent employer, claimant left work due to back pain. No doctor's report indicated that the claimant's inability to work was due to work at the subsequent employer. The Board found that the subsequent employer did not have notice of a claim when the claimant left work due to back pain. Instead, the Board found that the subsequent employer had notice upon receipt of a letter from the claimant's attorney, asserting a claim against the subsequent employer. Here, only one employer is involved and, as noted above, the work release notified that employer that claimant's condition was work related.

With the above supplementation, we adhere to our prior order. Accordingly, we withdraw our August 31, 1994 order. On reconsideration, as supplemented herein, we republish our August 31, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD R. ZIMBELMAN, Deceased, Claimant
WCB Case Nos. 93-02973 & 93-02972
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of those portions of Referee Spangler's order that: (1) set aside its denial of claimant's claim for a fatal myocardial infarction; (2) declined to direct claimant to reimburse the employer for the cost of a deposition; (3) awarded claimant 27 percent (40.5 degrees) and 9 percent (13.5 degrees) scheduled permanent disability for the right wrist and the left wrist respectively whereas an Order on Reconsideration had not awarded any scheduled permanent disability; and (4) found that claimant was entitled to additional temporary disability benefits. Claimant cross-requests review of that portion of the Referee's order that awarded a $3,000 assessed attorney fee for services at hearing concerning the compensability issue. On review, the issues are compensability, cost of deposition, extent of scheduled permanent disability, temporary disability, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the conclusions and reasoning concerning the compensability issue as set forth in the Referee's order. See Mathel v. Josephine County, 319 Or 235 (1994).

Deposition Costs

We adopt the conclusions and reasoning concerning the deposition costs issue as set forth in the Referee's order.

Scheduled Permanent Disability

The Referee awarded claimant 27 percent scheduled disability for the left wrist and 9 percent scheduled permanent disability for the right wrist. We disagree.

A claimant's beneficiaries are entitled to recover an injured worker's benefits. However, the claimant must be entitled to benefits before the claimant's beneficiaries can receive those benefits. ORS 656.218(1). In rating the permanent disability of an injured worker who has died prior to becoming medically stationary, only those impairment findings that are of a non-speculative nature, such as values for surgical procedures and amputations, shall be determined. OAR 436-35-007(17). Other impairment findings are of a speculative nature and will not be determined. Id.

Dr. Teal, claimant's attending physician, reported that claimant had reduced ranges of motion and reduced grip strength in both hands prior to claimant's death. However, Dr. Teal's findings were based on an examination performed at a time when claimant's condition was not medically stationary. Dr. Teal then estimated the percentage of claimant's impairment, based on the assumption that claimant's condition was medically stationary at the time of his death. Inasmuch as claimant was not medically stationary at the time of Dr. Teal's examination and Dr. Teal's findings are only estimations, these findings are speculative and cannot be used to determine impairment. OAR 436-35-005(17); Jeannie E. Spunaugle, 42 Van Natta 2546 (1990). Consequently, claimant (and, therefore, his beneficiaries) is not entitled to an award of permanent disability.

Temporary Disability Benefits

We adopt the conclusions and reasoning concerning the temporary disability benefits issue as set forth in the Referee's order.

Attorney Fees

We adopt the conclusions and reasoning concerning the attorney fee issue as set forth in the Referee's order with the following supplementation.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

Attorney Fees/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review concerning the compensability and temporary disability issues. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability and temporary disability issues is $1,725, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 3, 1994 is modified in part and affirmed in part. That portion of the Referee's order that awarded claimant 27 percent (40.5 degrees) scheduled disability for the left wrist and 9 percent (13.5 degrees) scheduled permanent disability for the right wrist, and awarded an "out-of-compensation" fee payable from these awards, is reversed. The Order on Reconsideration award of no permanent disability is reinstated and affirmed. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,725, to be paid by the self-insured employer.

In the Matter of the Compensation of
ROBERT L. GREER, JR., Claimant
WCB Case No. 94-05564
INTERIM ORDER OF DISMISSAL
Emmons, Kropp, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

The self-insured employer requested review of Referee Herman's order that: (1) awarded temporary disability (including an "out-of-compensation attorney fee payable from this compensation); and (2) assessed penalties and attorney fees for allegedly unreasonable claim processing. The parties have submitted a proposed "Stipulated Order," which is designed to resolve this dispute, in lieu of the Referee's order.

Specifically, in consideration for a Claim Disposition Agreement (CDA), which will soon be submitted for Board approval, the parties stipulate that the Referee's order shall be reversed and claimant's hearing request dismissed with prejudice. Claimant acknowledges that the exclusive vehicle for his compensation will be the CDA.

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of the Referee's order. In other words, claimant is not entitled to the temporary disability, penalties, or attorney fees awarded by the Referee's order.

In granting this approval, we note that the stipulation is effectively contingent on our subsequent approval of the parties' forthcoming CDA. In light of this contingency, we have granted our approval of the stipulation pursuant to this interim order. In this way, we may retain jurisdiction over this dispute in the unlikely event that final approval of the CDA does not materialize. In the more likely event, once CDA approval is granted, we shall issue a final, appealable order incorporating this interim order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TAMMY G. DODSON, Claimant
WCB Case No. 93-05827
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Hazelett's order that upheld the insurer's denial of claimant's occupational disease claim for a mental condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

On February 12, 1993, claimant received a written charge of tardiness when she failed to arrive at work at a new set time to which she had previously agreed. (Ex. A-21).

On February 15, 1993, claimant was given a written warning for calling in sick at 8:11 for a 7:00 shift, when claimant had been told to use the recorder within one-half hour of her assigned shift. (Ex. A-22).

On May 18, 1993, claimant again sought treatment for lack of sleep, difficulty in concentrating, and inability to cope, which she related to increased trouble at work. Dr. Peruzzo diagnosed severe anxiety, stress and depression. He recommended psychological counseling. (Exs. B-3).

On June 4, 1993, claimant sought treatment from Ms. Fath, LCSW, for complaints of sleep disturbance, frequent crying spells, muscle tension causing neck and stomach pain and jaw spasms, weight loss, anxiety and loss of libido. (Ex. 7-1).

CONCLUSIONS OF LAW AND OPINION

The Referee, assuming but not deciding whether claimant had a diagnosis of a mental or emotional disorder generally recognized in the medical or psychological community, concluded that claimant's occupational disease claim failed because claimant failed to prove that the conditions which allegedly caused her mental disorder were not generally inherent in the workplace.

We affirm and adopt the Referee's opinion with the following supplementation to address arguments raised on review.

Claimant first contends that she had a diagnosed mental or emotional condition recognized in the medical or psychological community. We agree.

On January 23, 1993, claimant sought treatment from Dr. Peruzzo, her family practitioner, complaining of lack of sleep, difficulty in concentrating, and inability to cope. Dr. Peruzzo treated her with medication. Claimant's symptoms resolved by February 15, 1993. On February 24, 1993, Dr. Klecan, psychiatrist, evaluated claimant's condition and concluded that she had no diagnosable psychiatric condition.

On May 18, 1993, claimant again sought treatment for lack of sleep, difficulty in concentrating, and inability to cope. Dr. Peruzzo diagnosed severe anxiety, stress and depression and recommended psychological counseling. Claimant was examined and counseled by Ms. Fath, LCSW, on June 4, 1993, June 11, 1993 and June 23, 1993 for complaints of sleep disturbance, frequent crying spells, muscle tension causing neck and stomach pain and jaw spasms, weight loss, anxiety and loss of libido. Claimant's symptoms rapidly subsided as a result of counseling.

Based on the rapid onset of symptoms with no history of similar symptoms prior to January 1993, and equally rapid decrease in symptoms over the month of treatment, Fath opined that claimant's symptoms met the criteria for Adjustment Reaction/PTSD, i.e., somatic and emotional symptoms in response to an acute identifiable stressor, namely, an accumulation of abuse at work and increased unfair treatment in January 1993. Dr. Kelleher, psychologist, concurred in this diagnosis after reviewing the medical record, a synopsis of events by claimant, a letter from claimant's brother-in-law, and administering the Millon Behavioral Health Inventory.

On December 10, 1993, Dr. Klein performed a psychiatric evaluation of claimant. She also reviewed records from the employer and medical and counselling records from claimant's doctors and counselor. She concluded that claimant had a great deal of stress on the job relating primarily to her relationship with her supervisor and a few of her co-workers. Dr. Klein opined that claimant did not have a psychiatric disorder, but instead had simple stress related to the relationships at work.

When the medical evidence is divided, we tend to give the greatest weight to the opinion of the treating doctor, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). We find there are no such reasons in this case. Although we recognize that Ms. Fath is not a licensed psychologist, her diagnosis is supported by Dr. Kelleher, who is a licensed psychologist, and who reviewed the medical record and tested claimant. See Aetna Casualty Co. v. Robinson, 115 Or App 154 (1991) (Qualifications affect the weight to be given to the opinion, not its admissibility). Furthermore, the symptoms of claimant's first episode of agitation, which had not required intervention by a psychologist or counsellor, had subsided prior to the time she was examined by Dr. Klecan, and the second episode had subsided prior to the examination by Dr. Klein. Therefore, we conclude that claimant experienced an emotional disorder generally recognized in the medical or psychological community.

Nevertheless, we conclude that claimant has failed to prove that the working conditions to which she was subjected are not conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer. See ORS 656.802(3)(b).

Claimant alleged that her treatment by Ms. Gurley, plant supervisor, resulted in denial of overtime work opportunities, requirements to do work that was beyond her physical capabilities, false charges of poor work performance, and being demeaned in public by her supervisors.

We first note that the Production Manager, John Smith, stated that the company felt that claimant was a very capable supervisor. This assessment is confirmed by the record, which indicates that claimant was given positions of responsibility by the employer in which she performed successfully. (Tr. 161-163). Nevertheless, the record also indicates that claimant became very upset by criticism of her work. Furthermore, there is no evidence that claimant was falsely charged with poor work performance or that she was publicly demeaned when her performance was corrected. (See Exs. A-1 through A-10). Moreover, there is also no evidence that claimant was unfairly denied overtime or required to work beyond her physical capacity.

Overtime: Mr. Smith explained that, after a year in which much overtime was worked by a number of employees, including claimant, the company decided to eliminate overtime wherever possible. There was no overtime on the day shift, whereas there was a possibility of occasional overtime on the evening shift. Claimant, as the senior employee, was allowed to choose which shift she preferred to work. She chose the day shift. Mr. Smith further explained that it was Ms. Gurley's job to see that overtime was kept to a minimum and that shifts were finished in a timely fashion. (Tr. 155-157).

Work Beyond Physical Capabilities: Mr. Smith also explained that, in the past, the employer had restricted claimant from heavy physical labor. This situation was grieved and claimant was considered eligible except for her medical restrictions. (Tr. 161, 162). Claimant had been restricted from lifting more than 10-15 pounds since an injury on March 8, 1991. On December 2, 1992, claimant experienced low back pain. She was treated and then released to return to work on December 4, 1992 without restrictions. (Exs. B-2 and A-11). On December 10, 1992, Dr. Peruzzo explained that claimant's 1991 lifting restriction of no more than 10-15 pounds was only for one week and was not meant as a permanent restriction. (Ex. A-12). Thus, in accord with the union contract and her seniority status, when claimant was released from her lifting restriction, she became eligible for a better-paying cooper position, which was offered to her. Also in accord with the union contract, a note was placed in the employee's file to document her refusal of the position on January 22, 1993. (Tr. 159, 160).

We find no evidence that claimant's working conditions were not conditions generally inherent in every working situation or reasonable disciplinary or corrective actions by the employer. Although there is some evidence that claimant may have been treated in a less than respectful manner by her immediate supervisor while taking corrective action, there is no evidence, in this record, that the corrective actions were unreasonable, or that this treatment rose to the level of an abusive work environment. See Michele M. Jimenez, 43 Van Natta 11 (1991) (We are unwilling to find an employer's corrective methods to be unreasonable based on claimant's reaction).

ORDER

The Referee's order dated January 24, 1994 is affirmed.

In the Matter of the Compensation of
DONALD A. JAMES, Claimant
WCB Case Nos. 93-11475, 93-05617, 93-06360, 93-09973 & 93-11474
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Meyers, Radler, et al., Defense Attorneys
Stoel, Rives, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Cigna Insurance Company (Cigna) requests review of those portions of Referee Peterson's order that: (1) set aside its disclaimer of responsibility for claimant's occupational disease claim for hearing loss; (2) upheld responsibility disclaimers for claimant's occupational disease claims for the same condition issued by Kemper Insurance Company (Kemper), Aetna Insurance Company (Aetna), Liberty Northwest Insurance Corporation (Liberty Northwest) and Western Employers Insurance (Western Employers); (3) dismissed the hearing requests from the disclaimers issued by Kemper, Aetna, Liberty Northwest and Western Employers; and (4) awarded an assessed attorney fee, payable by Cigna. On review, the issues are responsibility, disclaimer notice and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate fact.

CONCLUSIONS OF LAW AND OPINION

At the beginning of the hearing, claimant moved for dismissal of all insurers except Cigna. Claimant argued that Cigna had not issued a timely disclaimer of responsibility under ORS 656.308(2) and was thereby precluded from denying responsibility as to any other insurers. Claimant contended that because Cigna conceded compensability, it could no longer deny responsibility and it was therefore responsible for processing the claim. The other insurers joined claimant's motion for dismissal.

The Referee found that Cigna had received notice of claimant's claim on March 2, 1993, but had not issued a disclaimer of responsibility until April 27, 1993, more than 30 days after "actual knowledge of being named or joined in the claim" under ORS 656.308(2). (Exs. 30 & 31). Cigna formally denied compensability and responsibility for claimant's condition on May 28, 1993, although it later withdrew its compensability denial before the hearing. (Exs. 34 & 40). The other insurers denied responsibility for the claim. The Referee granted claimant's motion to dismiss and upheld the insurers' disclaimers of responsibility, set aside Cigna's disclaimer of responsibility, and awarded a carrier-paid attorney fee payable by Cigna.

Cigna argues that claimant was not prejudiced by its untimely disclaimer of responsibility since all potentially responsible insurers were joined as parties to the proceeding. According to Cigna, its failure to comply with the disclaimer requirements does not prevent it from asserting that one of the other insurers is responsible for the claim. We disagree.

The statutory language is clear. ORS 656.308(2) provides that an insurer which intends to disclaim responsibility "shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim." (Emphasis added). If an insurer has given proper notice, it "may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer." (Emphasis added).

Thus, the statute allows a responsibility defense if an insurer issues a timely disclaimer even if the claimant has not actually filed claims against other insurers. It follows that an insurer which does not comply with the disclaimer requirements is precluded from asserting a responsibility defense. Under ORS 656.308(2), prejudice to the claimant is not relevant to the analysis.

In Jon F. Wilson, 45 Van Natta 2362 (1993), we held that failure to follow the requirements of ORS 656.308(2) precluded a carrier from arguing that another employment exposure caused a claimant's need for medical services. See Byron E. Bayer, 44 Van Natta 1686, 1687 (1992). However, we further concluded that the claimant's failure to file a claim against a carrier within 60 days of the second carrier's disclaimer did not preclude the claimant from asserting compensability against the first carrier. We concluded that ORS 656.308(2) addresses responsibility for a claim and does not pertain to compensability. Therefore, in Wilson, we held that the claimant was not precluded from filing an occupational disease claim against the first carrier, pursuant to the filing requirements set forth in ORS 656.807(1).

Similarly, in Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994), we held that the carrier's failure to comply with the disclaimer notice of ORS 656.308(2) precluded the carrier from attempting to shift responsibility for the claim to another carrier. However, we concluded that the carrier's violation did not preclude the claimant from pursuing the compensability of her claim against the other carrier.

Here, unlike in Hamrick, claimant is no longer asserting a claim against other insurers. A claimant has no obligation to join any prior employers or insurers when the first carrier with whom the claimant filed a claim has failed to meet the requirements of ORS 656.308(2). See Wayne D. Helgerson, 45 Van Natta 1800 (1993) (as a result of the employer's failure to disclaim responsibility, the claimant was not required by ORS 656.308(2) to file a claim with another employer or insurer); Rene G. Gonzalez, 44 Van Natta 2483 (1992) (the claimant had no obligation to join any prior employers or insurers because the insurer waived any argument that responsibility should be assigned to a previous employer or insurer), on recon 45 Van Natta 499 (1993). Consequently, we hold that Cigna is precluded from attempting to shift responsibility for claimant's condition to another carrier.

Generally, an employer against whom a claim is made can avoid responsibility by proving that the claimant's disability was caused by a different employment or that the disability did not arise from any work-related injury. Boise Cascade v. Starbuck, 296 Or 238, 243 (1984). Consistent with this general principle, absent the ORS 656.308(2) disclaimer problem, Cigna's concession of compensability would not operate as a concession that claimant's condition was Cigna's responsibility. See Castle & Cooke v. Alcantar, 112 Or App 392, 395 (1992) (concession of compensability does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment).

However, under ORS 656.308(2), if an employer or insurer fails to comply with the disclaimer requirements, it may not assert as a defense that actual responsibility for claimant's disability lies with another insurer or employer. Here, it is undisputed that Cigna did not comply with the disclaimer requirements in a timely manner.

Notwithstanding an insurer's failure to comply with the disclaimer requirements of ORS 656.308(2), an insurer may continue to contest compensability. In Rachel J. Dressler-Iesalnieks, 45 Van Natta 1792 (1993), the insurer denied compensability and responsibility for the claimant's condition. We held that because the insurer had failed to comply with the notification provisions of ORS 656.308(2), the insurer was precluded from arguing that another employer was responsible for the claimant's condition. Nevertheless, we upheld the insurer's denial because the claimant did not establish that the work at insured caused a pathological worsening of the underlying condition. See also Wayne D. Helgerson, supra (addressing compensability issue when the insurer contested compensability at hearing, despite the fact that it failed to comply with ORS 656.308(2)).

Here, on May 28, 1993, Cigna initially denied the compensability of claimant's hearing loss claim as well as its responsibility for the claim. (Ex. 34). However, Cigna subsequently advised claimant on July 26, 1993 that it appeared that her bilateral hearing loss condition was compensable. (Ex. 40). At the November 15, 1993 hearing, Cigna expressly acknowledged that it had withdrawn its compensability denial. (Tr. 19). Cigna proceeded on the theory that it could argue responsibility because all the insurers were present and claimant would not be prejudiced.

Cigna's failure to comply with the disclaimer notice of ORS 656.308(2) precludes it from asserting as a defense that actual responsibility lies with another employer or insurer. Considering this statutory violation and its "responsibility only" defense, we conclude that Cigna is responsible for claimant's bilateral hearing loss condition.

Assessed Fee at Hearing

Cigna contends that the Referee erred in awarding claimant an assessed attorney fee, payable by Cigna. We agree that claimant was not entitled to a fee at hearing for prevailing over Cigna's responsibility disclaimer. Gamble v. Nelson International, 124 Or App 90 (1993). Nevertheless, we have held that a claimant's counsel is entitled to a carrier-paid attorney fee under ORS 656.386(1) when a carrier rescinds the compensability portion of its denial prior to a hearing regarding responsibility for the claim. See Penny L. Hamrick, supra.

Here, Cigna formally denied compensability and responsibility for claimant's condition on May 28, 1993. (Ex. 34). Cigna subsequently withdrew its compensability denial on July 26, 1993. (Ex. 40). We conclude that claimant is entitled to a fee for Cigna's pre-hearing rescission of its compensability denial. Accordingly, we affirm the assessed fee awarded by the Referee.

Claimant is entitled to an assessed attorney fee for prevailing over Cigna's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, to be paid by Cigna. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. (Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue in this case. Martin E. Mendez-Esquibel, 45 Van Natta 959 (1993); see Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986)).

ORDER

The Referee's order dated December 13, 1993 is affirmed. For services on Board review, claimant's attorney is awarded $750, payable by Cigna.

In the Matter of the Compensation of
MONTY L. TEETERS, Claimant
WCB Case No. 93-11173
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Black's order that assessed a $1,200 attorney fee under ORS 656.382(1) for allegedly unreasonable claims processing. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following corrections and supplementation.

Claimant sustained a compensable left ankle injury in December 1979 when he fractured the talus bone. The claim is in Own Motion status.

Two to three days prior to his September 16, 1993 left ankle surgery, claimant obtained crutches, but no wheelchair. On September 15, 1993, Dr. Jones, claimant's treating surgeon, prescribed crutches and a wheelchair for claimant for use during recovery from surgery. SAIF received the prescription on September 24, 1993. Claimant underwent left ankle fusion surgery on on September 16, 1993 and was discharged from the hospital on September 20, 1993. Claimant requested a hearing, on September 21, 1993, alleging a de facto denial of a wheelchair. On October 28, 1993, SAIF authorized the rental of crutches and a wheelchair.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts an entitlement to a wheelchair under ORS 656.245(1). An insurer must provide medical services for conditions resulting from any compensable injury for such period as the nature of the injury or the process of recovery requires. ORS 656.245(1)(a). Claimant's request is a claim for a compensable medical service within the meaning of ORS 656.245(1)(c). SAIF formally accepted the claim on October 28, 1993, well within the 90-day statutory limit. ORS 656.262(6).

In Syphers v. K-M Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981), the claimant requested a hearing on or about the same date his claim was filed. The Board dismissed the claim due to the premature filing of the request for hearing. The court affirmed, holding that until a claim is accepted or denied, or until the period of time has run during which an insurer may investigate the claim, there is no question concerning a claim on which to base a request for hearing and that a request for hearing made during that period of time is premature and void. See also Barr v. EBI Companies, 88 Or App 132 (1987).

In Michael A. Dipolito, 44 Van Natta 981 (1992), the carrier had received notice or knowledge of a claim regarding the claimant's request for surgery on February 15, 1991. Under ORS 656.262(6), the carrier had 90 days from that date in which to accept or deny the claim. The carrier authorized the surgery on March 25, 1991. We found that since no denial had issued (written or "de facto") prior to the claimant's February 28, 1991 request for hearing, that the request for hearing was premature. Because there had been no denial over which the claimant prevailed, we reversed the referee's award of an attorney fee under ORS 656.386(1).

In this case, SAIF received notice of the claim for a wheelchair on September 24, 1993 and authorized the rental of a wheelchair on October 28, 1993. Claimant filed a request for hearing alleging a de facto denial of medical services on September 21, 1993. Because claimant requested a hearing fewer than 90 days after SAIF had notice of the claim, his request for hearing was premature. Moreover, within 90 days of claimant's claim for a wheelchair, SAIF announced its acceptance. Accordingly, no "de facto" denial had occurred. Id.

The Referee awarded an assessed fee pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation. However, inasmuch as we have found that no denial occurred since SAIF timely accepted the claim, there has been no unreasonable resistance to the payment of compensation. Consequently, claimant is not entitled to an attorney fee pursuant to ORS 656.382(1). See Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991).

ORDER

The Referee's order dated January 19, 1994 is reversed.

Board Member Gunn specially concurring.

I believe, based on the evidence and the application of law, that SAIF Corporation's denial was technically not unreasonable. Just like Ollie North was technically not guilty of lying to Congress. However, I write to say that SAIF's failure to communicate directly with claimant will cost this carrier much more than any penalty we might impose.

This claimant has a history of surgeries. The recent surgery critically required that claimant stay off his feet. Because the claims adjustor did not communicate directly with claimant, claimant went without the wheelchair needed to insure a successful and complete recovery. This only increases the chances for future surgeries with the attendant costs that SAIF will have to pay. Everyone loses.

The establishment of direct communication between claimant and claims adjustor could have averted the dispute, the litigation, and foreclosed future liability to this carrier.

In the Matter of the Compensation of
RALPH L. WITT, Claimant
WCB Case No. C4-02216
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Black, Chapman, et al., Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Member Neidig and Hall.

On August 29, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Here, a portion of the settlement benefits have been assigned to claimant's wife in exchange for releasing her rights to survivor's benefits under ORS 656.204 and 656.208. (P. 4, ln. 22).

Specifically, the CDA provides that:

> "The parties also agree that any moneys paid to claimant's wife shall represent survivor's benefits contemplated by ORS 656.204 and ORS 656.208."

A "beneficiary" as provided by ORS 656.005(2) is "an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under this chapter."

ORS 656.208 provides in part;

> "(1) If the injured worker dies during the period of permanent total disability, whatever the cause of death, leaving a spouse or any dependents listed in ORS 656.204, payment shall be made in the same manner and in the same amounts as provided in ORS 656.204." (Emphasis supplied).

Therefore, for purposes of the statute, claimant's wife does not become a beneficiary until claimant dies during the period of permanent total disability (PTD). See ORS 656.208(1).

Here, the parties agree that there is substantial evidence supporting a contention that claimant is PTD, and the parties have valued the CDA benefits on that assumption. (P. 5, lns. 12-15). Nevertheless, claimant has not been found to be PTD and claimant is not deceased. Therefore, claimant's wife is not a beneficiary, and she may not release benefits to which she is not entitled through claimant's CDA. (CDA assigning portion of proceeds to spouse prior to receipt is unreasonable as a matter of law. See Robert K. Wilson, 45 Van Natta 1747 (1993).)

Furthermore, ORS 656.234 prohibits the assignment by an injured worker or any other beneficiary of any "moneys payable under ORS 656.001 to 656.807" prior to their receipt. Thus, because the agreement proceeds here are payable under ORS 656.236, such proceeds cannot be assigned by claimant to any entity or individual (including his spouse) prior to their receipt. See Debbie K. Ziebert, 44 Van Natta 51 (1992). However, following approval of a CDA which provides for payment of all proceeds to claimant, and after that full payment is made to claimant, there is no statutory prohibition restricting claimant from distributing all or any portion of the proceeds to his spouse or any other individual or entity. Therefore, for the above reasons, we conclude that the portion of the CDA providing payment to claimant's wife for release of survivor's benefits is unreasonable as a matter of law. Wilson, supra.

Because the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we conclude that we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES E. BOGLE, Claimant
WCB Case No. 93-04776
ORDER ON RECONSIDERATION
Pamela A. Schultz, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our August 11, 1994 Order on Review that upheld the SAIF Corporation's compensability denial. Specifically, claimant contends that we failed to consider his alternative argument that his psychological condition is compensable as an occupational disease pursuant to ORS 656.802.

On September 12, 1994, we withdrew our August 11, 1994 order for reconsideration. SAIF's response to claimant's motion has been received. Accordingly, we proceed with our reconsideration.

After reviewing claimant's motion, we conclude that we have previously considered claimant's occupational disease argument. In our original order, after reviewing the Referee's order and the record pursuant to our de novo review authority, we adopted and affirmed that portion of the Referee's order in which he analyzed claimant's condition as an occupational disease claim under ORS 656.802. We supplemented the Referee's order solely to address claimant's alternative argument on review that claimant's mental condition should be analyzed as an injury rather than an occupational disease. Because we have considered and decided all the issues raised, we continue to adhere to our prior order.

Accordingly, our August 11, 1994 order is withdrawn. On reconsideration, we adhere to and republish our August 11, 1994 order in its entirety, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEPHEN M. BRIGGS, Claimant
WCB Case No. 93-03109
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Quillinan's order that upheld the SAIF Corporation's denial of claimant's psychological condition claim. On review, the issue is compensability.

We adopt and affirm the Referee's order, with the following supplementation.

To establish the compensability of his psychological condition, claimant must prove that his employment conditions, excluding those enumerated in ORS 656.802(3)(b), were the major contributing cause of his disease. ORS 656.802(2), (3)(b). There must be clear and convincing evidence that the psychological condition arose out of and in the course of employment. ORS 656.802(3)(d).

Claimant has a long history of physical and psychological problems, including post-traumatic stress disorder, back and knee problems, depression and substance abuse. He was employed by the employer as a disability analyst from 1978 to April 1993 (minus a two-year gap between 1986 and 1988). During that time, claimant was disciplined numerous times for failing to process claims in a timely manner.

Claimant's current psychological condition arose in February 1993 following a series of disciplinary actions by the employer, including a one-step salary deduction in January 1993 related to claimant's failure to initially develop new claims in a timely manner. Claimant's other stressors included financial difficulties and alterations in his domestic situation (including moving in with a girl friend and having a son from Ireland come to live with him).

Two psychiatrists have rendered opinions regarding the cause of claimant's current psychological condition. Dr. Kuttner, one of claimant's treating psychiatrists, diagnosed adjustment disorder with mixed emotional features. (Ex. 206A-7). Kuttner concluded that, if claimant's history were accurate, the major cause of his adjustment disorder was his employment exposure. (Ex. 208). Kuttner then said:

> "I'm tempted to consider [claimant's psychological condition] as a recurrent depression at this point. * * * At this point I choose to call this an adjustment disorder because I see this as so eminently related to the recent events at work." (Id. at 39).

Dr. Parvaresh examined claimant on SAIF's behalf. Parvaresh diagnosed psychological factors affecting physical condition. (Ex. 205-6). During his deposition, Parvaresh stated that, if claimant had an adjustment disorder, it would have been caused by a combination of his financial, physical and psychological, domestic and work stressors. (See Ex. 212-58, -59). However, Parvaresh was unable to quantify the relative contribution of those stressors to claimant's psychological condition. He said:

> "I can't really quantify these except the fact by process of exclusion to say the day [claimant first sought treatment for his current psychological condition], had it not been for -- if he was on vacation for a month, he probably wouldn't have [sought treatment] because of [the non-work stressors]." (Id. at 63-64).

We find neither Drs. Kuttner's nor Dr. Parvaresh's opinions sufficient to meet claimant's burden of proof. Although both doctors acknowledged several, if not all, of claimant's off-work stressors, neither of them reached a meaningful and persuasive conclusion regarding the relative contribution of those stressors to claimant's current psychological condition. See Penny L. Wilson, 44 Van Natta 85 (1992) (Board unable to conclude that the claimant's mental disorder was compensable where medical experts failed to explain relative contribution of off-work stressor to disorder).

Furthermore, both Dr. Kuttner and Dr. Parvaresh rely almost solely on the close temporal relationship between the employer's discipline of claimant in late 1992 and early 1993 and the onset of his current psychological condition in February 1993 in concluding that that condition was compensably related to his work exposure. Because such a relationship will not, by itself, satisfy claimant's burden of proof, we afford Drs. Kuttner's and Parvaresh's opinions minimal probative weight. Pamela A. Burt, 46 Van Natta 415 (1994); see ORS 656.266.

For these additional reasons, we agree with the Referee that claimant has failed to establish the compensability of his current psychological condition.

ORDER

The Referee's order dated September 10, 1993 is affirmed.

In the Matter of the Compensation of
BONNIE R. BRUNER, Claimant
WCB Case Nos. 93-08823 & 93-08313
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
David O. Horne, Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Podnar's order that: (1) upheld Liberty Northwest's denial of claimant's aggravation claim for a neck and low back condition; (2) did not assess a penalty under ORS 656.262(10) for allegedly unreasonable claims processing; and (3) awarded a $500 attorney fee pursuant to ORS 656.382(1) for allegedly unreasonable claims processing. On review, the issues are aggravation and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

In 1981, claimant compensably injured his low back. The SAIF Corporation accepted and processed the claim, which included a laminectomy and fusion of claimant's back in 1986. Claimant eventually was awarded 30 percent unscheduled permanent disability.

In October 1989, claimant strained his neck and low back. Liberty Northwest accepted and processed the claim. A 1990 Notice of Closure awarded no additional permanent disability.

In May 1993, claimant again sought treatment for his neck and low back. Claimant asserted that he sustained a compensable aggravation of his 1989 injury. The Referee disagreed, finding that claimant's condition constituted only a waxing and waning of his condition without worsening. We first note that a temporary symptomatic worsening can constitute a compensable aggravation. See Smith v. SAIF, 302 Or 396 (1986). However, because we find no medical evidence showing that claimant's compensable injury with the insurer has worsened, we agree with the Referee's ultimate conclusion that claimant failed to prove a compensable aggravation.

Claimant did not join SAIF in this proceeding or allege that his 1981 injury compensably worsened in May 1993. Instead, claimant filed the aggravation claim only against Liberty. The medical evidence, however, shows that claimant's symptoms in 1993 were not related to his 1989 injury with Liberty's insured. Specifically, according to Dr. Waldram, claimant's treating orthopedic surgeon, claimant's increased low back symptoms were a waxing and waning of his condition that resulted from the 1986 surgery and his neck symptoms were a waxing and waning of degenerative arthritis. (Ex. 19-15, 19-19). Dr. Arbeene, an orthopedic surgeon who examined claimant on behalf of Liberty, agreed that claimant's symptoms were a waxing and waning of his 1981 injury and 1986 surgery. (Ex. 20-8, 20-18).

Therefore, in the absence of any evidence showing a worsening of claimant's 1989 condition, for which Liberty is responsible, claimant's aggravation claim fails. See ORS 656.273(1).

Penalty and Attorney Fees

After finding that Liberty failed to pay claimant sufficient interim compensation, the Referee further found that such conduct constituted unreasonable resistance to the payment of compensation and awarded a $500 attorney fee pursuant to ORS 656.382(1). Claimant asserts that the Referee "should have awarded a total penalty equal to 25 percent of the compensation due" rather than a $500 attorney fee award. We understand claimant as asserting that the Referee should have assessed a penalty pursuant to ORS 656.262(10) rather than ORS 656.382(1). We further note that Liberty does not dispute the Referee's finding that its failure to pay interim compensation was unreasonable.

A penalty for unreasonable conduct generally is assessed under ORS 656.262(10); however, a separate attorney fee award under ORS 656.382(1) may be granted for separate unreasonable conduct that relates to a different factual basis. See, e.g., Oliver v. Norstar, Inc., 116 Or App 333, 336 (1992). Here, claimant acknowledges that, under Martinez, he is limited to one-half of the penalty for Liberty's failure to pay the disputed interim compensation. Consequently, we reverse the Referee's $500 attorney fee award under ORS 656.382(1). Instead, we agree with claimant that it is more appropriate for a penalty to be assessed under ORS 656.262(10). Thus, as a penalty, Liberty shall pay an additional amount of 25 percent of the interim compensation awarded under the Referee's order, one-half payable to claimant's attorney.

Furthermore, for his efforts at hearing in obtaining increased interim compensation, claimant's attorney is entitled to 25 percent of the increased interim compensation awarded by the Referee, not to exceed $1,050, to be paid out of the increased compensation. See ORS 656.382(2); OAR 438-15-045. In the event that the interim compensation award, or any portion thereof, has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994).

ORDER

The Referee's order dated November 30, 1993 is affirmed in part and reversed in part. The Referee's $500 attorney fee award under ORS 656.382(1) is reversed. Pursuant to ORS 656.262(10), as a penalty, Liberty shall pay an additional amount of 25 percent of the interim compensation awarded under the Referee's order, one-half to claimant's attorney and one-half to claimant. Liberty also shall pay 25 percent of the increased interim compensation awarded by the Referee, not to exceed $1,050, to claimant's counsel. In the event that the interim compensation award, or any portion thereof, has already been paid to claimant, claimant's attorney may seek recovery of the "out-of-compensation" fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994). The remainder of the order is affirmed.

In the Matter of the Compensation of
CHRISTOPHER C. CIONGOLI, Claimant
WCB Case No. 93-09498
ORDER ON REVIEW
Aspell, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Mongrain's order which set aside its denial of claimant's right ankle injury claim. Claimant cross-requests review of the Referee's finding that claimant's injury was the result of misconduct. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

We do not adopt the finding that claimant was driving "too fast."

At the time of claimant's injury (which resulted from a motorcycle accident in his employers' parking lot), two tractor trailers were parked at the side of the roadway to the employer's parking lot, and blocked normal access to the exit of the employer's premises.

CONCLUSIONS OF LAW AND OPINION

The employer's premises is a large compound consisting of several buildings, parking lots, a railroad track and interconnecting roadways. On June 11, 1993, after 12:30 a.m. when claimant was leaving work, his usual course of travel toward the exit of the premises was blocked by two large truck trailers. The trailers had not been parked in that area when claimant arrived at work, and they were parked outside the area specifically marked for trailer parking. (Tr. 12). The area was dark, and claimant's view of the two trailers was blocked by other trailers parked in designated spots. As claimant rounded a corner and headed toward the exit, rather than heading through the area where the trailers were parked as he usually did, claimant was required to quickly alter his route. As he did so, claimant's motorcycle slipped on some gravel that had been displaced from a large pothole. Claimant put his right foot down as he began to slide and his right foot hit chunks of asphalt, catching his ankle and breaking it.

The Referee concluded that claimant was "probably going too fast," therefore he was engaging in misconduct. Nevertheless, because the evidence was inconclusive as to "how fast" claimant was driving, the Referee concluded that claimant's driving did not break the work connection. We conclude that the claim is compensable. This conclusion is based on the following reasoning.

In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted a unitary "work-connection" approach for assessing whether the relationship between claimant's injury and employment is sufficient to render an injury compensable. Id. at 642. Citing Clark v. U.S. Plywood, 288 Or 255, 260 (1980), the Court recently explained that there are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arise out of employment" tests the causal connection between the injury and the employment. Norpac Foods v. Gilmore, 318 Or 363 (1994). Both elements must be evaluated; neither is dispositive.

As a general rule, injuries sustained by employees when going to and coming from their regular workplace are not deemed to arise out of and in the course of their employment. SAIF v. Reel, 303 Or 210, 216 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). There are, however, exceptions to the general rule.

One such potential exception is the "parking lot rule." The "parking lot rule" holds that, if an injury occurs in a parking lot or other off premises area over which the employer has some control, the injury may be compensable. Control is manifested by: (1) employer ownership or maintenance, see Montgomery Ward v. Cutter, 64 Or App 759 (1983), Janet V. Dollens, 42 Van Natta 2004 (1990), aff'd mem 107 Or App 531 (1991); (2) employer actions, see Montgomery v. SAIC, 224 Or 380 (1960); or (3) the presence of employer created special hazards, see Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971).

In Norpac Foods v. Gilmore, supra, the Supreme Court recently elaborated on the "parking lot rule." The Court explained that application of this rule establishes only that the time, place, and circumstances of the injury are sufficiently work-related to satisfy the threshold "in the course of" element, but that the second element of the work-connection inquiry must also be satisfied. Thus, to prove compensability, claimant must also establish that his injury "arose out of" his employment. In other words, claimant must also establish a sufficient causal connection between his employment and the injury to prove compensability.

To establish that an injury "arose out of" employment, the claimant must prove that there is some causal connection between the injury and his or her employment. Norpac Foods, Inc. v. Gilmore, supra, 318 Or at 368-69. In a "parking lot" case, that causal connection exists when the claimant's injury was brought about by a condition or hazard associated with premises over which the employer exercises some control. See Montgomery Ward v. Malinen, 71 Or App 457 (1984) (fall on icy pavement employer had legal duty to maintain); Ronald. R. Nelson, 46 Van Natta 1094 (1994) (fall on rough pavement on employer-controlled driveway); see also William F. Gilmore, 46 Van Natta 999, 1000 (1994) (order on remand) (injury sustained while the claimant entered his vehicle on employer's parking lot held not compensable, because it did not arise from risk associated with the lot). In other words, claimant must prove that his employment conditions put him in a position to be injured. See Henderson v. S.D. Deacon Corporation, 127 Or App 333 (1994).

Here, there is no dispute that claimant's injury occurred on the employer's premises, thus the "course of employment" element has been satisfied. Montgomery Ward v. Cutter, supra. Furthermore, we conclude that claimant's injury was brought about by a condition or hazards (including the inappropriately parked trailers, and the large pothole and gravel) associated with premises over which the employer exercises control. Ronald. R. Nelson, supra.

The insurer argues that claimant's injury was the result of reckless and unsafe driving which constituted prohibited conduct and, thus, was an activity outside the course and scope of employment. Notwithstanding the fact that the Referee also concluded that claimant was engaging in misconduct by probably driving his motorcycle too fast, we conclude that the evidence is inconclusive as to what constituted "fast driving on the premises" (Ex. 7-1), and whether claimant was, in fact, driving too fast.

There is no evidence in the record that the parking lot through which claimant was travelling had posted speed limits. Claimant testified that he was travelling at approximately 15 miles per hour and that he was in first gear when the accident occurred. (Tr. 9, 10). Mr. Kenyon and Mr. Wencl, employer witnesses, testified that, although they did not see claimant before the fall, they could hear that his motorcycle engine was "winding up," which indicated a high rate of speed. (Tr. 59-60, 74-75).

The Referee based his conclusion that claimant was going too fast in large part on his apparent finding that the employer witnesses testified credibly. However, we are not persuaded that the testimony is entirely credible.

When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Here, in addition to the rate of speed claimant was travelling, both witnesses also testified as to the condition of the pavement in the area where claimant fell. Each stated that there was no defect in the pavement, or any potholes or gravel near the area. (Tr. 45, 78-79).

The record, however, contains photographs of the employer's roadway taken by claimant four days after his accident. (Exs. 8, 9). The photographs show a large pothole filled with loose gravel. After the employer's witnesses testified that there was no pothole or gravel in the pavement when they examined the accident area, claimant introduced the photographs, and testified that the pictures he had taken were an accurate representation of the condition of the roadway at the time of his accident, except that the gravel had been swept back into the pothole.

The employer does not dispute claimant's assertions concerning the gravel and pothole. Rather, the employer argues the witnesses should have been confronted with the photographs at hearing in order to undermine the credibility of the witnesses.[1] Notwithstanding the employer's contentions, we conclude that the credibility of the witnesses was definitely called into question when, after specifically testifying that there was no gravel or pothole in the roadway, claimant introduced photographs to the contrary, and testified that his motorcycle slipped in the gravel when he had to suddenly adjust his route to avoid running into the tractor trailers taking up extra space in the roadway.

Accordingly, after our review of the record, we conclude that the testimony of the employer's witnesses was not credible. In light of such a conclusion, we find no persuasive evidence in the record to substantiate the employer's contention that claimant was driving too fast on the premises, and that that misconduct took claimant outside the course and scope of his employment. We, therefore, affirm the Referee's order.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $900, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 27, 1993 is affirmed. For services on Board review, claimant's attorney is awarded a $900 attorney fee, payable by the self-insured employer.

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[1] Mr. Wencl was shown the photograph at the time he testified, but the employer objected because no testimony had been given concerning when the photograph was taken. Claimant, on rebuttal, provided that information.

In the Matter of the Compensation of
KEITH D. KILBOURNE, Claimant
WCB Case No. 93-04279
ORDER ON RECONSIDERATION
Whitehead & Klosterman, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

On September 9, 1994, we modified the Director's vocational eligibility order to direct the SAIF Corporation to provide vocational assistance. In addition, we awarded a $1,500 carrier-paid attorney fee under ORS 656.382(2) and an "out-of-compensation" attorney fee under ORS 656.386(2). Noting that the "opinion" section of our decision sets a maximum "out-of-compensation" fee of $1,050, while the "order" section sets a $2,800 maximum fee, claimant seeks clarification.

Claimant requested a hearing from the Director's order. The Referee vacated the Director's order and directed SAIF to resubmit the vocational claim to the Director. The Referee did not award an attorney fee. SAIF requested Board review. We modified the Referee's order and directed SAIF to provide vocational assistance. Inasmuch as claimant had requested a hearing, but not Board review, and since only temporary disability would eventually arise from our decision, we awarded an "out-of-compensation" attorney fee, not to exceed $1,050. See OAR 438-15-045. Nevertheless, the "order" section of our decision erroneously set the maximum "out-of-compensation" attorney fee at $2,800.

Consequently, in the interests of clarifying this inconsistency, we issue this reconsideration order. In addition to the carrier-paid attorney fee granted in our prior order, claimant's attorney is allowed an "out-of-compensation" fee equal to 25 percent of the increased temporary disability compensation arising from our order, not to exceed $1,050.

Accordingly, we withdraw our September 9, 1994 order. On reconsideration, as supplemented herein, we republish our September 9, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Hall, specially concurring.

For the reasons expressed in my previous special concurring opinion, I continue to believe that ORS 656.386(1) is applicable. Nevertheless, since I am bound to apply the holding of Simpson v. Skyline, 108 Or App 721 (1991), I concur with the conclusion that claimant's counsel's fee is "out-of-compensation" under ORS 656.386(2).

Board Members Haynes and Neidig specially concurring.

We continue to believe that the Director correctly applied the appropriate rules in determining that claimant was not eligible for vocational assistance. However, since the majority of the Board members found otherwise, we shall adhere to that prior conclusion.

We write separately only to express our agreement with the conclusion that, when a represented claimant is successful in overturning a Director's adverse vocational service decision, his counsel's "out-of-compensation" attorney fee is payable from the temporary disability which would arise once the carrier would begin to process the vocational claim.

In the Matter of the Compensation of
ROBERT E. ROY, Claimant
WCB Case No. 93-02753
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Menashe's order which: (1) affirmed an Order on Reconsideration awarding no scheduled permanent disability for loss of use or function of the right foot; and (2) increased claimant's unscheduled permanent disability award for the low back from 4 percent (12.8 degrees), as awarded by Order on Reconsideration, to 7 percent (22.4 degrees). On review, the issues are extent of scheduled permanent disability and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

The parties stipulated to a value of +3 for the non-medical factors (age, education and adaptability) in rating unscheduled permanent disability. (Tr. at 10; Opinion and Order at 3; Respondent's Brief at 2).

CONCLUSIONS OF LAW AND OPINION

A November 25, 1992 Determination Order awarded claimant 14 percent (44.8 degrees) unscheduled permanent disability for his low back, and 2 percent (2.7 degrees) scheduled permanent disability for loss of use or function of the right foot (lower leg). (Ex. 30).

Claimant requested reconsideration. A February 8, 1993 Order on Reconsideration reduced claimant's unscheduled permanent disability award to 4 percent (12.8 degrees) and the scheduled permanent disability award to zero. (Ex. 33).

The Referee increased claimant's unscheduled permanent disability award to 7 percent (22.4 degrees), and affirmed that portion of the Order on Reconsideration which awarded no scheduled permanent disability.

We apply the standards in effect on the date of determination, November 25, 1992. (Ex. 30). Therefore, the appropriate standards are found in WCD Admin. Order 6-1992, effective March 13, 1992.

For rating the extent of claimant's permanent impairment, we rely on the closing examination of Dr. Duff, orthopedist, as concurred in by neurologist Dr. Rosenbaum, the attending physician. (Exs. 27, 28). ORS 656.245(3)(b)(B); OAR 436-35-007(8).

Scheduled Permanent Disability

After our review of the record, we agree with the Referee's determination that claimant is not entitled to an award of scheduled permanent disability for loss of use or function of his right foot.

Dr. Duff found decreased sensation in the lateral thigh and lower calf, as well as the medial aspects of the foot and great toe. (Ex. 27-5). However, there is no medical evidence of loss of plantar sensation in the foot. Only loss of plantar sensation is ratable under the standards. Former OAR 436-35-230(1); 436-35-200(1). Therefore, claimant is not entitled to any impairment for loss of sensation in his right lower extremity.

Claimant also contends that he is entitled to an impairment value of 1 percent for loss of strength in his right great toe flexor, which Dr. Duff measured as 4+/5. (Ex. 27-5). Loss of strength is rated when the cause is peripheral nerve injury, and the value of impairment is determined by the specific nerve affected. Former OAR 436-35-230(9); see also Verna N. Hess, 46 Van Natta 1471, 1472 (1994).

Here, Dr. Duff found loss of strength in the right great toe flexor, but he did not identify the specific peripheral nerve responsible for the loss of strength. (See Ex. 27-5). Accordingly, we agree with the Referee's determination that the 4+/5 loss of strength in the right great toe flexor is not ratable under the standards. See Verna N. Hess, supra.

Claimant contends that if his impairment is not ratable, his claim should be remanded to the Director for promulgation of a temporary rule under ORS 656.726(3)(f)(C). Claimant first raised this issue on review.

We have authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. See Gallino v. Courtesy Pontiac-Buick GMC, 124 Or App 538 (1993). Inasmuch as the standards include a rule which addresses loss of muscle strength, it is arguable whether this is an appropriate claim to remand to the Director for adoption of a temporary rule. However, we need not address that question because claimant did not preserve this issue for our review.

Unlike the worker in Gallino, claimant did not request the Director to adopt a temporary rule. Claimant also failed to make a remand request to the Referee. Rather, claimant's remand request is made for the first time on review. We do not consider issues raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Brian G. Vogel, 46 Van Natta 225 (1994).

Unscheduled Permanent Disability

The Referee excluded the measurements of lumbar flexion and extension on the ground that they did not meet the straight leg raising (SLR) validity test set forth in the Director's November 9, 1992, Bulletin No. 242 (Rev.) at page 7. In doing so, the Referee approved the Appellate Reviewer's application of the test on reconsideration. (See Ex. 33-3).

We disagree with the Referee's application of the SLR validity test. Accordingly, we conclude that the lumbar flexion and extension measurements made by Dr. Duff, the medical arbiter, are valid. (See Ex. 27-4).

The Director's rules provide that only the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., 1990) and methods the Director may prescribe by bulletin shall be used to measure and report impairment. OAR 436-35-007(4). The Director has prescribed by bulletin the SLR method for testing the validity of lumbar flexion. That method provides that "measurements of true lumbar flexion are invalid if the tightest straight leg raising (SLR) angle is not equal to or within 10 degrees of the sum of the lumbar extension and flexion measured at midsacrum." Bulletin No. 242, supra, at 7. The same bulletin also provides, as a general principle, that "[m]easurements which do not meet the validity criterion shall be noted in the examiner's report." Id. at 2. Thus, we conclude that the Director's bulletin contemplates that the validity determination will be made by the medical examiner performing the range of motion tests, and that any invalid measurements will be identified by that examiner.

Here, the medical arbiter did not note any measurements as being invalid. Indeed, in the discussion portion of his report, Dr. Duff concludes that claimant has "significant restriction of motion" in the lumbar spine, and that there is "a mild degree of permanent impairment affecting the lumbar spine . . . on the basis of loss of range of motion." Dr. Duff further notes that claimant's complaints are "clearly consistent with the physical findings documented." (Ex. 27-6). Thus, we conclude that, since Dr. Duff did not identify any invalid measurements, we have no basis for independently finding the measurements invalid.[1] Accordingly, inasmuch as we find that the medical arbiter's range of motion measurements satisfy the Director's validity criterion, we accept those measurements as valid.

For loss of lumbar flexion, 35 degrees retained, claimant is entitled to 4 percent impairment. OAR 436-35-360(19). For loss of extension, 6 degrees retained, claimant is entitled to 5.8 percent impairment. OAR 436-35-360(20). (See Ex. 27-4). These values are added to the 4.4 percent impairment value for loss of left and right lateral flexion, for a total of 14.2 percent impairment. OAR 436-35-360(22). This value is rounded to the nearest whole number for 14 percent impairment. OAR 436-35-007(13).

The parties stipulated to a value of +3 for the non-medical factors (age, education and adaptability) in rating unscheduled permanent disability. Inasmuch as we find no evidence that the stipulation was unfairly obtained, we accept the parties' agreement. Dana W. Wood, 44 Van Natta 2241, (1992); Verna N. Hess, supra.

When the non-medical factor value of 3 is added to the impairment value of 14, the result is 17 percent unscheduled permanent disability. Former OAR 436-35-280. Accordingly, we modify the Order on Reconsideration and find claimant entitled to 17 percent unscheduled permanent disability for his low back condition.

Offset

The Referee authorized the insurer to offset permanent disability compensation paid pursuant to the Determination Order against the increased permanent disability awarded by the Referee's order. Inasmuch as our order results in an overall increase in permanent disability compensation paid to claimant, there is no longer an offset issue.

Attorney Fees

Inasmuch as this order increases claimant's permanent disability award, claimant's counsel is entitled to an attorney fee payable from the increased compensation. ORS 656.386(2). In awarding an attorney fee, we rely upon our recently issued decision in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994). In Volk, the issue presented was whether an insurer was required to pay an "out-of-compensation" attorney fee award to a claimant's attorney, where the permanent disability award (including the portion which represented the attorney fee award), had already been paid to the claimant. We concluded that the claimant's counsel was entitled to an attorney fee, since the attorney

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[1] We note, parenthetically, that the validity criterion may not have been correctly applied by the Appellate Reviewer and the Referee. The Director's bulletin requires comparing the sum of lumbar extension and flexion measured at midsacrum with the tightest SLR angle. The medical arbiter's report does not identify any extension or flexion measurements made at midsacrum. We find no basis for concluding, as the Referee and Appellate Reviewer did, that the lumbar flexion and extension measurements reported by the medical arbiter are equal to flexion and extension measured at midsacrum. (See Ex. 33-3). Indeed, we doubt that that is a valid assumption. Compare Director's Bulletin No. 242, supra, at 6 and Director's Form 440-2278 (8/92/COM) at 2.

was instrumental in establishing the claimant's entitlement to a permanent disability award and had obtained a "substantive increase" in the claimant's permanent disability award.

Similarly, in the present case, we find that claimant's attorney has been instrumental in obtaining a substantive increase in claimant's permanent disability, as follows:

(1) At hearing, a 3 percent increase (7 percent unscheduled disability, less 4 percent unscheduled disability awarded by the Order on Reconsideration); and

(2) on Board review, a 10 percent increase (17 percent unscheduled disability, less 7 percent unscheduled disability awarded at hearing).

Consequently, claimant's attorney is entitled to an attorney fee equal to 25 percent of this increased compensation, not to exceed $3,800. ORS 656.386(2); OAR 438-15-055(1). In the event that this substantively increased permanent disability award, or any portion thereof, has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Volk, supra.

ORDER

The Referee's order dated January 7, 1994 is modified. In addition to the Referee's award of 7 percent (22.4 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability, for a total award of unscheduled permanent disability to date of 17 percent (54.4 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event that this increased compensation has already been paid to claimant, claimant's attorney is authorized to seek recovery of the fee in the manner prescribed in Jane A. Volk, supra.

In the Matter of the Compensation of
BENJAMIN G. SANTOS, Claimant
WCB Case No. 93-11469
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Lipton's order which: (1) affirmed an Order on Reconsideration awarding 17 percent (54.4 degrees) unscheduled permanent disability for a low back condition; (2) declined to award additional temporary disability compensation beyond claimant's medically stationary date; and (3) approved the SAIF Corporation's request to offset an overpayment in the amount of $320 against future awards of permanent disability. On review, the issues are extent of unscheduled permanent disability and temporary disability. We affirm.

FINDINGS OF FACT

On January 7, 1991, claimant sustained a low back and right hip injury while working for the employer. (Ex. 1).

On December 5, 1991, SAIF issued a Notice of Acceptance for a lumbar strain. (Ex. 9).

On October 15, 1992, Dr. Flemming, the attending physician, performed a closing examination at SAIF's request. (Ex. 2-7). Dr. Flemming reported 36 degrees forward flexion, 16 degrees extension, 22 degrees right lateral flexion, and 16 degrees left lateral flexion. (Id).

On November 2, 1992, claimant was examined at Western Medical Consultants by Drs. Snodgrass and Dinneen, at SAIF's request. They considered claimant capable of performing his regular job. (Ex. 29-4). They measured lumbar flexion at 44 degrees, but found this measurement invalid. (Ex. 29-3).

On November 17, 1992, Dr. Flemming responded to the Consultants' report. He did not concur with their report, noting specifically that it would be difficult for claimant to return to his job-at-injury due to the lifting requirements of that job. However, Dr. Flemming agreed that claimant's condition was medically stationary. (Ex. 30).

A January 6, 1993 Determination Order awarded claimant periods of temporary disability, in addition to an award of 18 percent (57.6 degrees) unscheduled permanent disability. (Ex. 32-1). In calculating the permanent disability award, claimant's lumbar flexion was determined to be 32 degrees. (Ex. 32-2).

Claimant requested reconsideration on July 1, 1993, requesting a medical arbiter examination. (Ex. 40).

On September 3, 1993, Dr. James MacD. Watson conducted a medical arbiter examination. He measured true lumbar flexion at 15 degrees, extension at 20 degrees, right lateral flexion at 4 degrees, and left lateral flexion at 16 degrees. However, he found the lumbar flexion measurement to be invalid. (Ex. 42 at 2-3).

An Order on Reconsideration issued on September 22, 1993, which did not consider the medical arbiter's lumbar flexion finding. (Ex. 44-4). The Order on Reconsideration reduced claimant's permanent disability award to 17 percent (54.4 degrees).

On September 30, 1993, SAIF notified claimant that an overpayment in the amount of $320 resulted from the reduction in his permanent disability award. (Ex. 45).

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

We apply the standards in effect on the date of determination, January 6, 1993. (Ex. 32). Therefore, the appropriate standards are found in WCD Admin. Order 6-1992, effective March 13, 1992. The standards for rating unscheduled permanent disability are found at OAR 436-35-270 through 436-35-450.

The only factor in contention at hearing and on review is claimant's loss of lumbar flexion. The Referee found that the record failed to establish any value for lumbar flexion on which he could rely. Therefore, he affirmed the Order on Reconsideration. We agree, but we do so based on the following reasoning.

The Director's rules provide that when a medical arbiter is used on reconsideration, impairment is determined by the medical arbiter, unless a preponderance of medical opinion establishes a different level of impairment. OAR 436-35-007(9). Impairment findings made by a consulting physician may be used only if the attending physician concurs with those findings. OAR 436-35-007(8). Otherwise, only the attending physician at the time of claim closure may make impairment findings. ORS 656.245(3)(b)(B).

The Director's rules further provide that only the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., 1990) and methods the Director may prescribe by bulletin shall be used to measure and report impairment. OAR 436-35-007(4). The Director has prescribed, by Bulletin No. 242 (Rev.), dated November 9, 1992, methods for measuring mobility in the lumbar spine, including the straight leg raising (SLR) method for testing validity of lumbar flexion. Bulletin No. 242, supra, at 6-7. That bulletin also provides, as a general principle, that the medical examiner shall note measurements which do not meet the validity criterion. Id. at 2.

Here, on reconsideration, Dr. Watson performed a medical arbiter examination. (Ex. 42). Dr. Flemming, the attending physician, made impairment findings in October 1992. However, we do not find his measurements more persuasive than the medical arbiter's, since Dr. Flemming does not indicate whether he performed any validity tests. (See Ex. 2-7). The attending physician has not concurred with any other impairment findings. Therefore, we find Dr. Watson's opinion concerning claimant's impairment findings to be more persuasive.

Dr. Watson measured 15 degrees of true lumbar flexion. However, he noted that this measurement is not valid, based on the SLR method of testing the validity of lumbar flexion measurements. In other words, Dr. Watson found that the tightest SLR angle (40 degrees) was not equal to or within 10 degrees of the sum of lumbar flexion and extension measured at midsacrum (25 degrees). See Director's Bulletin No. 242, supra, at 7; (Ex. 42-3).

Based on Dr. Watson's persuasive opinion, we conclude that the lumbar flexion measurement was properly excluded from the calculation of claimant's impairment. Therefore, we affirm the Order on Reconsideration.

Temporary Disability and Offset

We adopt and affirm that portion of the Referee's order which held that claimant is not entitled to additional temporary disability compensation after his medically stationary date. Jimmie G. Clark, 45 Van Natta 2308 (1993); see also Thomas M. Aldrich, 46 Van Natta 1025 (1994) (Lebanon Plywood v. Seiber, 113 Or App 651 (1992) followed regarding entitlement to substantive temporary disability).

We also adopt and affirm the Referee's offset authorization.

ORDER

The Referee's order dated January 13, 1994 is affirmed.

September 27, 1994 Cite as 46 Van Natta 1914 (1994)

In the Matter of the Compensation of
MICHAEL D. WALKER, Claimant
WCB Case No. 93-10334
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Garaventa's order which affirmed an Order on Reconsideration awarding claimant 26 percent (83.2 degrees) unscheduled permanent disability for his low back condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction and supplementation.

In early 1993 (not 1992), claimant transferred to a less strenuous job, but the aching and stiffness in his back did not improve. (Ex. 22-2). See Opinion and Order at 2.

The medical arbiter did not identify any lumbar range of motion measurements as being invalid. (See Ex. 33 at 2-4).

CONCLUSIONS OF LAW AND OPINION

In evaluating the extent of claimant's unscheduled permanent disability, we find that the Referee applied the disability standards in effect on the date of the Notice of Closure, June 2, 1992, as modified by temporary rules that became effective June 17, 1993. WCD Admin. Order 6-1992 (effective March 13, 1992); WCD Admin. Order 93-052 (temp. rules, effective June 17, 1993).

Based on these standards, the Referee concluded claimant was entitled to an unscheduled permanent disability award of 25 percent. The Order on Reconsideration awarded 26 percent. However, because SAIF did not request reduction of the award, the Referee affirmed the Order on Reconsideration.

Specifically, the Referee found that claimant was entitled to an adaptability value of 1, because claimant returned to his regular heavy work without restrictions. The Referee also found that claimant was entitled to an impairment value of 21 percent, based, in part, on the conclusion that the medical arbiter's lumbar flexion measurement could not be used because it was invalid. (See Ex. 33-2).

On review, claimant contends that his adaptability value should be 3, and the impairment value should be 27 percent. SAIF does not request a reduction in the award made by the Order on Reconsideration.

Subsequent to the hearing date in this matter, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994).

Because claimant became medically stationary on April 14, 1992, and his claim was closed by Notice of Closure on June 2, 1992, the appropriate standards for rating claimant's disability are in the permanent rules adopted effective March 13, 1992. WCD Admin. Order 6-1992. Accordingly, we proceed to evaluate the extent of claimant's unscheduled permanent disability under those standards.

Impairment

The Referee excluded the lumbar flexion measurement made by the medical arbiter on the ground that it did not meet the straight leg raising (SLR) validity test set forth in the Director's November 9, 1992, Bulletin No. 242 (Rev.) at page 7. In doing so, the Referee approved the Appellate Reviewer's application of the SLR test on reconsideration. (See Ex. 34-4). Claimant contends that the impairment value should be 27 percent, because the Referee erred in excluding the lumbar flexion measurement made by the medical arbiter. (Ex. 33-2). We agree.

The Director's rules provide that only the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., 1990) and methods the Director may prescribe by bulletin shall be used to measure and report impairment. OAR 436-35-007(4). The Director has prescribed by bulletin the SLR method for testing the validity of lumbar flexion. That method provides that "measurements of true lumbar flexion are invalid if the tightest straight leg raising (SLR) angle is not equal to or within 10 degrees of the sum of the lumbar extension and flexion measured at midsacrum." Bulletin No. 242, supra, at 7. The same bulletin also provides, as a general principle, that "[m]easurements which do not meet the validity criterion shall be noted in the examiner's report." Id. at 2. Thus, we conclude that the Director's bulletin contemplates that the validity determination will be made by the medical examiner performing the range of motion tests, whether a medical arbiter, treating physician, or other medical examiner, and that any invalid measurements will be identified by that examiner.

Here, the medical arbiter did not note any measurements as being invalid. However, the Referee found that the medical arbiter's measurements indicated an invalid lumbar flexion measurement, because the sum of the flexion angle (16 degrees) and extension angle (6 degrees) was not within 10 degrees of the tightest straight leg raising angle (50 degrees). (See Ex. 33-2); Opinion and Order at 3.

We question whether the Referee correctly applied the validity criterion, since the Director's bulletin provides for a comparison of the sum of lumbar flexion and extension measured at midsacrum with the tightest SLR angle. Furthermore, we note that the medical examiner in this case did not identify any invalid measurements, nor is there any other basis in this record to question the validity of the measurements. Under these circumstances, we find the reported measurements to be valid.

Therefore, we conclude that the Referee erred in excluding the lumbar flexion measurement of 16 degrees made by the medical arbiter. (Ex. 33-2). Accordingly, for loss of lumbar flexion, 16 degrees retained, claimant is entitled to 7 percent impairment. OAR 436-35-360(19).

Claimant does not dispute any other impairment findings. The 7 percent impairment for lumbar flexion is added to 11 percent impairment for other losses of lumbar range of motion, for a total of 18 percent impairment due to lost range of motion. We further find that claimant is entitled to an 11 percent impairment value for surgery, which is combined with the 18 percent value for lost range of motion, for a total impairment value of 27 percent. (Exs. 33-2, 34-4). OAR 436-35-360(22), (23).

Social/Vocational Factors

Claimant contends that he is entitled to an adaptability value of 3, rather than 1 as found by the Referee. We disagree.

Pursuant to former OAR 436-35-290(2), 436-35-300(2), and 436-35-310(2), for workers who have a physician's release to regular work, or who have returned to regular work at the time of the determination, the value for the age, education and adaptability factors is zero. "Regular work" is defined as "substantially the same job held at the time of injury, or substantially the same job for a different employer." Former OAR 436-35-270(3)(c). Accordingly, we first determine whether claimant was released to, or returned to, his regular work at the time of determination.

At the time of determination in June 1992, claimant had returned to his regular job as a municipal maintenance worker. (See Exs. 1, 14-3 to -4, 20, 25-4). His attending physician at the time of closure, Dr. Becker, noted that claimant was working without limitations in April 1992, and he found no need for restrictions. (Exs. 23, 25-4). He had been working full time in his regular job since June 1991, following his second low back surgery in August 1990. (Ex. 22-1). Dr. Jeppesen, who had been the attending physician, immediately prior to Dr. Becker, concurred with Dr. Becker's April 1992 report. (Ex. 26). Claimant did not transfer to a "less taxing" job until early 1993, but his back condition remained unchanged from one year earlier. (Ex. 22-2).

Under these circumstances, we conclude that at the time of determination claimant was released to, and returned to, his regular job. Therefore, claimant is entitled to a value of zero for the factors of age, education and adaptability.

We now assemble the factors to determine claimant's permanent disability. The age and education factors total zero. Former OAR 436-35-280(4). That value is multiplied by the adaptability factor of zero, resulting in a value of zero. Former OAR 436-35-280(6). That product is added to the impairment value of 27 percent, resulting in a total of 27 percent unscheduled permanent disability. Former OAR 436-35-280(7).

ORDER

The Referee's order dated January 24, 1994 is modified. In addition to the Referee and Order on Reconsideration award of 26 percent (83.2 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, for a total award to date of 27 percent (86.4 degrees) unscheduled permanent disability. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800.

Board Member Hall specially concurring.

I acknowledge that the Board's decision in Michelle Cadigan, 46 Van Natta 307 (1994), compels the result in this case. However, I write separately to express my continued disagreement with the Cadigan decision, as set forth in my dissent in that case. Id. at 310-13.

Under the applicable disability standards, claimant is not entitled to any value for age, education, or adaptability if his physician releases him to, or he returns to, his "regular" work. Former OAR 436-35-290, 436-35-300, 436-35-310; see also former OAR 436-35-270(3)(b), (c). As explained in the dissent in Cadigan, I believe these standards are contrary to the statutory mandates that disability shall be rated based on the permanent loss of earning capacity due to the compensable injury, which in turn is determined by permanent impairment as modified by the factors of age, education, and adaptability to perform a given job. ORS 656.214(5); 656.726(3)(f)(A); see also England v. Thunderbird, 315 Or 633 (1993).

The standards applicable here apparently operate on the premise that a worker has suffered no permanent loss of earning capacity if he or she returns to, or is released to, regular work. This case illustrates the fallacy of that assumption.

Here, claimant in fact sustained a permanent loss of earning capacity, even though at the time of determination he had returned to, and was released to, his "regular" work. For example, after his second low back surgery, claimant's treating physician repeatedly recommended that claimant be retrained for, or transferred to, less physically strenuous work as a long-term solution to claimant's chronic back problem. (Exs. 17, 18-3, 19). Although he released claimant to his regular work, Dr. Doupe' saw a real potential for re-injury, despite claimant's precautions and avoidance of aggravating body positions. (Ex. 20). Thus, although claimant was "technically" released to, and returned to, his regular work, the record indicates that claimant would be unable to sustain working in his regular job over the long term.

That claimant in fact sustained permanent loss of earning capacity, despite his return to regular work, is borne out by the medical arbiter's physical capacity assessment. (See Ex. 33). The medical arbiter found that claimant, whose regular job as a water maintenance engineer required relatively heavy physical labor (excavation, shoveling and laying pipe), was limited to lifting and carrying in the "light/sedentary" capacity range, was unable to use his back for repetitive bending or lifting, had limited capacity to sit, stand and walk on a continuous basis, and was permanently precluded from frequently stooping, crouching, crawling, kneeling, and twisting. (Ex. 33-4). However, under the applicable standards and our decision in Cadigan, claimant receives no compensation for the impact of these limitations on his earning capacity simply because he returned to his regular work.

Indeed, by the time of the arbiter's examination, claimant had succeeded in transferring to a less physically demanding job. (Ex. 22-2). Thus, the medical arbiter's finding that claimant "is able to work full time at his regular job," despite limitations due to back and leg discomfort, refers to the physically less demanding control room job, not to his job at the time of injury. (See Ex. 33-2).

Here, claimant clearly has sustained reduced earning capacity as a result of the compensable injury, for which he receives no compensation as a result of our decision in Cadigan. Consistent with my dissent in Cadigan, I believe the applicable disability standards, which allow a value for the factors of age, education and adaptability only if claimant has not returned to, nor been released to, regular work, remain contrary to the statutory mandate.

September 28, 1994 Cite as 46 Van Natta 1917 (1994)

In the Matter of the Compensation of
BETTY J. BRENCE, Claimant
WCB Case No. 93-11089
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Spangler's orders that: (1) denied the insurer's motion to dismiss claimant's hearing request; (2) ruled certain testimony admissible; and (3) granted claimant permanent and total disability. On review, the issues are jurisdiction, evidence, and permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and provide the following addition.

Before hearing, the insurer moved to dismiss claimant's hearing request. Relying on the Board's order in Darlene K. Bentley, 45 Van Natta 1719 (1993), the insurer contended that, because claimant failed to raise entitlement to permanent and total disability on reconsideration, she was precluded from asserting the issue at hearing. The Referee denied the motion, reasoning that claimant had raised a permanent total disability issue on reconsideration by raising entitlement to scheduled permanent disability which "can result in permanent total disability."

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

On review, the insurer reiterates its argument that claimant was precluded at hearing from raising the issue of permanent total disability. Therefore, the insurer contends that the Referee erred in failing to grant its motion to dismiss claimant's request for hearing.

Following the Referee's order, the Court of Appeals found no statutory preclusion to raising an issue at hearing that was not argued on reconsideration and held that the claimant in that case should have been allowed to raise the issue of scheduled permanent disability before the Referee even though that issue was not first presented on reconsideration. Leslie v. U.S. Bancorp, 129 Or App 1, 5 (1994). Therefore, based on Leslie, we conclude that the Referee properly allowed claimant to raise entitlement to permanent total disability even though the issue was not expressly asserted during the reconsideration proceeding.

Evidence

The insurer next challenges the Referee's ruling allowing into evidence the testimony of Byron McNaught, a vocational assistance counselor who testified on behalf of claimant. Specifically, the insurer contends that McNaught's testimony is inadmissible because his opinion relied on a post-reconsideration interview with claimant and, therefore, was based on evidence generated after reconsideration. See ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

In Smith, the court held that, although the Referee is required under ORS 656.283(7) to evaluate a claimant's disability as of the date of the reconsideration order, evidence relating to disability that was not submitted on reconsideration could be considered by the Referee at hearing. 122 Or App at 163. Here, although McNaught first testified that he based his opinion in part on a post-reconsideration interview with claimant, in accordance with the Referee's instructions, McNaught then limited his opinion to claimant's condition at the time of the reconsideration order. (Tr. 56-59). Therefore, since McNaught's testimony related to claimant's condition at the time of reconsideration, we find no contravention of ORS 656.283(7). See Juanita A. Ravencroft, 46 Van Natta 314 (1994).

Furthermore, even if McNaught's opinion was based on the post-reconsideration interview, we would continue to find his testimony admissible. As the Referee found, claimant's condition did not change between the date of the reconsideration order and hearing. Therefore, any post-reconsideration information obtained by McNaught would be relevant to claimant's condition at the time of reconsideration and admissible. See Gary C. Fischer, 45 Van Natta 60 (1994).

Thus, whether based on the medical record in existence when the order on reconsideration issued or post-reconsideration information, we find that ORS 656.283(7) does not preclude admission of McNaught's testimony. Inasmuch as the insurer's argument regarding admissibility is premised only on ORS 656.283(7), we do not consider the application of any other possible statutory prohibition against admissibility.

Permanent Total Disability

We adopt and affirm the conclusions and reasoning concerning the permanent total disability issue as set forth in the Referee's order.

Although claimant filed a brief on review, it was rejected as untimely. Consequently, claimant is not entitled to an assessed attorney fee, under ORS 656.382(2) for prevailing over the insurer's request for review. Shirley M. Brown, 40 Van Natta 879, 882 (1988).

ORDER

The Referee's order denying the insurer's motion to dismiss dated November 23, 1993, is affirmed. The Referee's order dated January 28, 1994, as reconsidered February 8, 1994, is affirmed.

In the Matter of the Compensation of
DARRELL D. HENDRIX, Claimant
WCB Case Nos. 93-08163 & 93-04569
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee McWilliams' order which upheld the self-insured employer's current condition denial of claimant's injury claim for a cervical condition. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation.

Claimant sustained a work-related injury on August 5, 1992. On October 19, 1992, the employer issued a denial of claimant's "current condition," but did not specifically name the condition. On October 20, 1992, the employer accepted a disabling thoracolumbar strain. The accepted claim was closed by a November 3, 1992 Notice of Closure which awarded temporary disability benefits from August 11, 1992 through August 24, 1992. On July 7, 1993, the employer issued a second partial denial of claimant's current cervical condition.

Claimant argues that the employer was precluded from issuing its July 7, 1993 denial of claimant's current cervical condition because Referee Black had previously found the condition compensable. We do not agree.

At the previous hearing, Referee Black concluded, relying on Guerrero v. Stayton Canning Co., 92 Or App 209 (1988), and Roller v. Weyerhaeuser Co., 67 Or App 583, amplified on recon 68 Or App 743 (1984), that the employer had issued a procedurally improper preclosure denial on October 19, 1992. Subsequent to the Referee's order in the present case, the Board affirmed Referee Black's order. Darrell D. Hendrix, 46 Van Natta 421 (1994). The Board reasoned that, because the employer did not specifically state a separate condition that it was denying in its October 19, 1992 denial, its partial denial was not valid. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34, 38 (1989) (partial denial of "degenerative changes with mild osteophytic spurring" was sufficiently specific); see also Tattoo v. Barrett Business Service, 118 Or App 348, 353-54 (1993) (preexisting spleen condition unrelated to accepted lumbosacral sprain).

Accordingly, because of the procedural error in issuing a nonspecific preclosure denial, the Board affirmed the prior Referee's order setting aside the employer's partial denial. By doing so, however, neither the Referee nor Board addressed the compensability of claimant's current condition. See Woodie R. Striplin, 42 Van Natta 2439 (1990). Therefore, compensability of claimant's current cervical condition was properly before the Referee in the present case.

ORDER

The Referee's order dated December 3, 1993 is affirmed.

In the Matter of the Compensation of
VALORIE L. LESLIE, Claimant
WCB Case No. 92-02861
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Miller, Nash, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Leslie v. US Bancorp, 129 Or App 1 (1994). The court has reversed those portions of our prior order, Valorie L. Leslie, 45 Van Natta 929 (1993), which: (1) declined to address claimant's request for scheduled permanent disability; and (2) declined to remand the claim to the Director for promulgation of a temporary rule regarding the Director's disability standards. Holding that neither ORS 656.268(4)(e) nor ORS 656.283(7) precludes a claimant from raising an issue for the first time at hearing, the court has remanded for reconsideration

of claimant's entitlement to scheduled permanent disability. Citing Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993), the court has also remanded for reconsideration of our decision not to remand to the Director.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A Notice of Closure awarded 6 percent (19.2 degrees) unscheduled permanent disability for a right shoulder injury. Claimant requested reconsideration, seeking the adoption of a disability rating standard regarding her right shoulder surgery.

A February 10, 1992 Order on Reconsideration awarded 11 percent (35.2 degrees) unscheduled permanent disability. In its reconsideration order, the Department found that claimant's disability was addressed by the standards and declined to promulgate a temporary rule amending the standards pursuant to ORS 656.726(3)(f)(C). After a hearing, the Referee found that there was no evidence that the standards did not adequately address claimant's impairment due to this surgery. The Referee increased claimant's unscheduled permanent disability award to 13 percent (41.6 degrees).

Contending that the Director's disability rating standards do not address her impairment due to her right shoulder surgery, claimant seeks remand to the Director for adoption of a temporary rule. We conclude that remand is not justified.

Under ORS 656.726(3)(f)(C), the Director shall stay further proceedings and shall adopt temporary rules when "it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph." The Board has authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. Gallino v. Courtesy Pontiac-Buick-GMC, supra. Claimant has the burden of proving that her disability is not addressed by the standards. See ORS 656.266; Susan D. Wells, 46 Van Natta 1127 (1994).

Here, the Department found that claimant's disability was adequately addressed by the standards. Specifically, the Department found that claimant's anterior capsular reconstruction surgery was not considered an impairment under the standards. The Department further noted that any residuals of the surgery would be evidenced by recurrent dislocation, weakness or loss of motion. On this basis, the Department concluded that claimant's disability was addressed by the standards and that promulgation of a rule pursuant to ORS 656.726(3)(f)(C) was not appropriate. (Ex. 57-5).

In support of her argument that the Director's disability rating standards do not address her impairment, claimant contends that there is no reason that the standards should provide for an impairment rating for back surgery, but not provide a similar rating for her right shoulder surgery. On the basis of this argument, claimant contends that a temporary rule should have been adopted by the Director.

Claimant points to no evidence in the record, and we can find none, which supports her assertion that the standards do not adequately address her impairment. To the contrary, based on the Department's Order on Reconsideration, the record supports a finding that any disability resulting from claimant's shoulder surgery are addressed in the Director's existing standards. Accordingly, on this record, we conclude that claimant has failed to prove that the standards do not adequately address her disability. See Susan D. Wells, supra (the Board had no authority to remand to the Director pursuant to ORS 656.726(f)(C) where the claimant did not prove that the standards did not adequately address her disability).

Claimant also seeks an increased unscheduled award. Specifically, she contends that she is entitled to a value of 1 for the age factor. The disability rating standards in effect on the date of the November 7, 1991 Notice of Closure, WCD Admin. Orders 2-1991 and 7-1991, apply to claimant's claim. OAR 436-35-003(2).

On the date of the Notice of Closure, claimant was 39 years old and thus, would not have been entitled to a value for age under the standards. However, as of the date of the reconsideration order, claimant was 40. In our prior order, we adopted the Referee's order which found, among other things, that claimant's age was rated at the time of the Notice of Closure. Subsequent to the date of the Referee's order, and our prior order, the court held that a claimant's disability should be rated as of the date of the reconsideration order under ORS 656.283(7). Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). Accordingly, we find that claimant, who was 40 years old at the time of the reconsideration order and who did not have a release to and had not returned to her regular work, is entitled to a value of 1 for her age. See Former OAR 436-35-290(2).

Claimant does not challenge the Referee's values for education (2), adaptability (4), and impairment (5). Thus, claimant's age (2) and education (1) values are added to equal 3. When that value is multiplied by the adaptability factor (4), the result is 12. This value is added to claimant's impairment factor (5) to equal 17. Claimant's unscheduled impairment under the standards is 17 percent (54.4 degrees). Former OAR 436-35-280. Consequently, the Referee's order awarding a total of 13 percent is increased to 17 percent.

Finally, claimant seeks an award of scheduled disability. In our prior order, we had held that claimant was not entitled to scheduled permanent disability because she had not raised that issue before the Department on reconsideration of a Notice of Closure. Valorie L. Leslie, supra.

In reversing that portion of our prior order, the court cited ORS 656.283(7) and Safeway Stores, Inc. v. Smith, supra, which held that a referee is authorized to consider evidence that could not have been submitted to the Department on reconsideration. Noting that the statute was silent about whether a party may raise issues which had not been presented during the reconsideration proceeding, the court reasoned that there was no statutory or administrative preclusion from doing so. Leslie v. US Bancorp, supra. On this basis, the court held that claimant should have been allowed to raise her entitlement to scheduled permanent disability before the Referee. Accordingly, we proceed to address claimant's entitlement to scheduled permanent disability.

Based on the medical arbiter's report, claimant seeks an award for pinch and grip weakness in the right extremity or for a chronic condition in the right arm. Dr. Smith, the medical arbiter, found a 4/5 weakness of grip and pinch on the right. The applicable standards provide for an impairment value where loss of strength in the upper extremity is caused by peripheral nerve injury, loss of muscle, disruption of the musculo tendonous unit, spinal nerve root injury or brachial plexus injury. See former OAR 436-35-110(2)(a), (7) and (8). Here, however, Dr. Smith did not find any nerve or muscle involvement to account for these weaknesses. Accordingly, claimant has not established entitlement to an award for loss of strength.

Former OAR 436-35-010(6) provides that a worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. Here, Dr. Smith stated that claimant has a chronic and permanent medical condition due to the injury and subsequent surgery, which will prevent heavy or repetitive use of her arm. Based on Dr. Smith's opinion, we conclude that claimant has established entitlement to an award of 5 percent impairment for a chronic condition of the right arm.

Claimant has finally prevailed on the extent of permanent disability issue. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services. Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991). This fee shall be in addition to the "out-of-compensation" award granted by the Referee's order and this order for claimant's counsel's successful efforts in obtaining increased scheduled and unscheduled permanent disability awards.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services before the court is $1,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We further note that claimant's counsel is not entitled to an attorney fee for claimant's unsuccessful efforts regarding the "remand" issue. Finally, we have also taken into consideration the fact that claimant's counsel shall also receive "out-of-compensation" attorney fees payable from claimant's increased permanent disability awards.

Accordingly, on reconsideration, the Referee's order dated June 11, 1992 is modified. In addition to the Notice of Closure, Order on Reconsideration and Referee awards totalling 13 percent (41.6 degrees) unscheduled permanent disability for a right shoulder injury, claimant is awarded 4 percent (12.8 degrees), for a total award to date of 17 percent (54.4 degrees) unscheduled permanent disability. Claimant is also awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly by the insurer to claimant's attorney. For services before the court, claimant's attorney is awarded $1,500, payable by the self-insured employer.

IT IS SO ORDERED.

September 28, 1994 Cite as 46 Van Natta 1922 (1994)

In the Matter of the Compensation of
ROBERTO RODRIGUEZ, Claimant
WCB Case No. 93-06124
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
James Booth (Saif), Defense Attorney

Claimant requests reconsideration of our August 30, 1994 order that reversed a Referee's order which had affirmed an Order on Reconsideration award of 31 percent (99.2 degrees) unscheduled permanent disability for a low back condition. Asserting that we erred in evaluating the medical opinions which addressed his permanent impairment, claimant seeks reconsideration of our decision that he was not entitled to permanent disability.

In order to further consider this matter, we withdraw our August 30, 1994 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

September 29, 1994 Cite as 46 Van Natta 1922 (1994)

In the Matter of the Compensation of
FLORENCE ANDREWS, Claimant
WCB Case Nos. 92-14559, 92-14036, 93-03709, 93-03017, 92-08484 & 93-03708
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (on behalf of Malheur County Mental Health Department) requests review of those portions of Referee Peterson's order that: (1) set aside its denial of claimant's cerebral vascular accident (stroke) claim; and (2) set aside its denial of claimant's consequential condition claim for an adjustment disorder and depression. Claimant cross-requests review of that portion of the Referee's order that awarded a $5,000 attorney fee. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following clarification.

On December 16, 1991, Dr. Daniels, claimant's family physician, advised Liberty's insured that working "on call" was creating high levels of stress and anxiety in claimant. He requested, therefore, that claimant's "on call" schedule be "altered." In response, the insured changed the nights claimant

worked "on call." Claimant was otherwise scheduled to work the same number of "on call" shift rotations and hours each month.

CONCLUSIONS OF LAW AND OPINION

Compensability/Stroke

Applying ORS 656.802, the Referee concluded that claimant's stress-related stroke is compensable. On review, Liberty concedes that "claimant had stress from work, which led to her migraine, which led to her stroke[.]" Liberty contends, however, that because claimant has not established a compensable mental condition under ORS 656.802(3), her stroke claim fails. We agree with and adopt the Referee's ultimate conclusion that claimant's stroke is compensable. However, we do so based on the following reasoning.

Subsequent to the Referee's order, the Supreme Court rejected the view that any claim based on stress must be analyzed as an occupational disease claim. Mathel v. Josephine County, 319 Or 235 (1994). In Mathel, the claimant suffered a heart attack due to high stress levels at work. The Court found that the alleged cause of a condition does not determine whether the claim is for an injury or a disease. Rather, interpreting ORS 656.005(7)(a) and ORS 656.802, the Court concluded that it is whether the condition is an event or an ongoing condition or state of the body or mind that determines whether the claim is for an injury or a disease. Id. at 240. The Court then held that a heart attack, even one precipitated by job stress, is an injury within the meaning of ORS 656.005(7), which is compensable if it meets the statutory requirements for accidental injuries. Id. at 242-43.

We find the Mathel Court's analysis applicable to the instant case. Like the heart attack in Mathel, claimant's stroke fits the criterion for an injury, that is, it was a sudden event, not an ongoing condition. See James v. SAIF, 290 Or 343, 348 (1981). Therefore, notwithstanding that claimant's stroke was precipitated by job stress, we analyze the claim as one for an accidental injury.

In order to prevail under an injury theory, claimant must establish, by medical evidence supported by objective findings, that her work activities were a material contributing cause of her disability or need for medical treatment. ORS 656.005(7)(a)(A). Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991). Claimant has carried her burden of proof.

We adopt the Referee's opinion from the second paragraph on page 4 through the top of page 5. As did the Referee, we rely on treating neuropsychiatrist Ball's opinion, as concurred in by Drs. Burdic and Daniels, and find that claimant's on-the-job stress produced a "complicated migraine" with vascular spasm that led to claimant's stroke. Moreover, we note that Liberty concedes that claimant's job stress led to her migraine, which led to her stroke. Accordingly, we find that claimant has established by a preponderance of the evidence that her work activities were a material contributing cause of her stroke. ORS 656.005(7)(a)(A); Mathel v. Josephine County, supra. The Referee's order setting aside Liberty's May 27, 1992 denial is, therefore, affirmed.

Compensability/Adjustment Disorder and Depression

The Referee also set aside Liberty's July 15, 1992 denial of claimant's consequential condition claim for an adjustment disorder and depression. On review, Liberty does not dispute that claimant's stroke produced an adjustment disorder and depression. Rather, it argues that, inasmuch as claimant's stroke is not compensable, neither are her adjustment disorder and depression.

As we have found herein, claimant's stroke is compensable. Because Liberty concedes that claimant's stroke caused her adjustment disorder and depression, it follows that claimant's consequential psychological condition claim for adjustment disorder and depression is also compensable. ORS 656.005(7)(a)(A); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Boeing Co. v. Viltrakis, 112 Or App 396 (1992).

Attorney Fees

The Referee awarded claimant an assessed fee of $5,000 for prevailing at hearing over Liberty's denials. On review, claimant seeks an assessed hearing level fee of $12,145.50. In support of this request, claimant submits an affidavit from her counsel and a "timeslip" summary report. Filing no reply in response to claimant's cross-request, Liberty does not express disagreement with the Referee's award.

In determining a reasonable fee for claimant's counsel's services at hearing, we consider the factors set forth in OAR 438-15-010(4). Those factors include: "(a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill and standing of the attorneys; (e) the nature of the proceeding; (f) the result secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses." Inasmuch as the Referee's order does not indicate that the aforementioned rule was applied, we proceed with our evaluation of those factors in reaching our determination of a reasonable attorney fee award.

The hearing in this matter was conducted over two days. Claimant's counsel's firm devoted over 100 hours of time to this case at the hearing level.

This matter involves a complex claim for a stroke condition and a consequential claim for psychiatric disorders. Because the claims were found to be compensable, claimant will be entitled to necessary medical care for her physical and psychiatric conditions, and to possible future awards of permanent disability.

Thirteen witnesses testified during this adversarial hearing; 70 exhibits were admitted.

Claimant's counsel bore a significant risk of his efforts going uncompensated in this complicated case.

Considering the above factors and applying them to this case, we award $9,000 as a reasonable assessed attorney fee for claimant's counsel's efforts in prevailing at hearing over Liberty's denials. In reaching this conclusion, we have particularly considered the time devoted to the compensability issues (as represented by the record and claimant's counsel's statement of services), the value of the interests involved, the complexity of the issues, and the risk that claimant's counsel might go uncompensated. We have also taken into consideration that, as a result of the Referee's penalty assessment for an unreasonable denial under ORS 656.262(10), claimant's counsel will also receive, in lieu of an attorney fee, one-half of the 25 percent penalty based on all amounts then due as a result of the Referee's compensability finding.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issues is $1,500, to be paid by Liberty Northwest Insurance Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. No attorney fee is available for that portion of claimant's brief devoted to the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated June 18, 1993 is affirmed in part and modified in part. In lieu of the Referee's award of a $5,000 attorney fee for services at hearing, claimant is awarded a $9,000 attorney fee, to be paid by Liberty Northwest Insurance Corporation. The remainder of the order is affirmed. For services on review concerning the compensability issues, claimant's attorney is awarded a reasonable fee of $1,500, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
LEONA M. BROOKS, Claimant
WCB Case No. 93-03591
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Meyers, Radler, et al., Defense Attorneys

On August 11, 1994, we withdrew our July 13, 1994 Order on Review that: (1) affirmed the Referee's penalty award for an unreasonable discovery violation; and (2) modified the Referee's order to award an assessed attorney fee for an unreasonable denial. We took this action to consider the employer's assertions that: (1) there was no basis for a penalty award pursuant to ORS 656.262(10), because the discovery violation did not result in a delay of claimant's compensation; and (2) the employer's denial was not unreasonable because it had legitimate doubt regarding the compensability of claimant's occupational disease claim.

Having received claimant's response, we proceed with our reconsideration. After reconsidering these issues and the parties' respective positions, we continue to adhere to our prior decision, with the following supplementation.

Discovery Violation

As a preliminary matter, the employer does not dispute that its counsel's April 27, 1993 cover letter to Dr. Neufeld (requesting an independent medical examination) was discoverable after the actual examination had been performed on May 10, 1994. (Exs. 18-B & 17A); See OAR 438-07-015. However, the employer argues that "the independent medical examination of Dr. Neufeld was so favorable to claimant's position, that the employer incorrectly concluded that [claimant] would no longer want that document." (Mot. for Recon. at 2). Thus, the employer reasons that its failure to disclose the letter until June 14, 1993 (four days after the hearing convened) was not unreasonable.

OAR 438-07-015(4) provides that all documents acquired after the initial request for discovery shall be disclosed within 7 days after the disclosing party's receipt of the documents. (Emphasis supplied). Furthermore, OAR 438-07-015(5) provides that failure to comply with the discovery procedures shall, if found unreasonable, be considered delay or refusal under ORS 656.262(10).

Analyzing the circumstances most favorably for the employer, we are still unable to conclude that its discovery violation was reasonable. Specifically, inasmuch as claimant's counsel made an express written request to discover the employer's counsel's cover letter on May 24, 1993, (Ex. 22), the employer's assumptions regarding whether claimant still wished discovery is not a viable defense; particularly considering that the abovementioned cover letter had been authored by the employer's counsel on April 27, and the subsequent report from Dr. Neufeld was in the employer's possession no later than May 21, 1993. (Mot. for Recon. at 2).

Primarily, the employer argues that its failure to comply with the relevant provisions of OAR 438-07-015 is not by itself a sufficient basis for the assessment of an attorney fee. Relying on Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), the employer contends that penalties may not be assessed under ORS 656.262(10) unless its actions constitute an unreasonable resistance to the payment of compensation or otherwise unreasonably causes a delay in compensation.

In Jackson, the court reiterated the Supreme Court's holding that failure to provide discovery can interfere with the payment of compensation. 108 Or App at 257. However, in Jackson, the court found that an attorney fee award was improper because the employer had paid the entire award of compensation prior to the discovery violation and thus, there was no unreasonable resistance to the payment of compensation. Id.

Here, compensability of claimant's occupational disease claim was directly at issue during the hearing. Furthermore, the Referee was compelled to leave the record open for the receipt of the employer's counsel's cover letter to Dr. Neufeld. (Tr. 41). Finally, the Referee ultimately determined that the claim was compensable. Under such circumstances, we conclude that Jackson, supra, is distinguishable.

The employer further contends that neither the Referee nor the Board made a finding that the discovery violation resulted in unreasonable delay or resistance to payment of compensation. We disagree. The Referee stated:

> "the examination took place May 10, 1993 but the [April 27, 1993 cover letter to Dr. Neufeld] was not provided to claimant's attorney until June 14, 1993. There is no reason given for the delay which prevented closure of this record at the June 10, 1993 hearing. I conclude the delay is on its face unreasonable." (Emphasis supplied) (Opinion and Order at 6).

Pursuant to our July 13, 1994 Order, we adopted the Referee's reasoning and stated: "We agree that the employer's delay in providing discovery was unreasonable and that a penalty was properly assessed pursuant to OAR 438-07-015(5)." (Emphasis supplied) (Order on Review at 2).

Based on the aforementioned circumstances, we conclude that the employer's discovery violation manifested an unreasonable delay in the payment of compensation justifying the assessment of a penalty under ORS 656.262(10). See OAR 438-07-015(5); See also Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991) (Failure to comply with discovery requirements may be unreasonable resistance to the payment of compensation under ORS 656.382(1), even when there is no evidence that the noncompliance delayed acceptance of the claim).

Unreasonable Denial

The employer contends that we erroneously awarded claimant an unsolicited assessed attorney fee under ORS 656.382(1). Specifically, the employer asserts that claimant did not raise the issue of penalties and attorney fees for an unreasonable denial. We disagree.

Claimant's Request for Hearing enumerated the issues to be resolved as: "compensability," "penalty," and "attorney fee." At hearing, claimant initially presented the issues as compensability of an occupational disease claim and penalties for an unreasonable denial. (Tr. 1). Claimant subsequently asked that the Referee also determine whether attorney fees and penalties were assessable based on the employer's discovery violation. (Tr. 40-41). The employer did not object to the raising of this issue.

The Referee issued an initial Opinion and Order on August 26, 1993. The Referee found that the employer's denial was no longer reasonable after it received the medical opinion of Dr. Neufeld, who examined claimant at the employer's request. The Referee found that the employer's failure to timely provide discovery of the cover letter to Dr. Neufeld was unreasonable as well.

Based upon those two separate instances the Referee awarded two separate penalties pursuant to ORS 656.262(10). The employer requested reconsideration of that order on the grounds that the award of penalties may not exceed 25 percent of the compensation then due. See Robert A. Brooks, Jr., 44 Van Natta 1105 (1992); Mollie E. Barrow, 43 Van Natta 617 (1991). The Referee agreed and issued an amended order on November 2, 1993 to award the same penalty, but solely based upon the employer's unreasonable denial of claimant's shoulder condition (i.e., the amended order did not award an attorney fee for the discovery violation).

On review, claimant's respondent's brief sought penalties based on two instances of allegedly unreasonable conduct: (1) the discovery violation; and (2) the unreasonable denial. Claimant proceeded to separately argue the unreasonableness of each act as the basis for a penalty.

We accepted claimant's arguments that each act individually merited a penalty award, although we noted that there is no legal authority for assessing penalties totalling more than 25 percent of the compensation then due. Robert A. Brooks, Jr., supra; Mollie E. Barrow, supra. However, inasmuch as we determined that claimant had successfully established two separate instances of unreasonable conduct, we concluded that there was legal authority to award a penalty under ORS 656.262(10) and an attorney fee under ORS 656.382(1) as originally noted by claimant's Request for Hearing. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Under these circumstances, we continue to find our decision to award both a penalty and an attorney fee is consistent with claimant's arguments at hearing and on Board review.

In the alternative, the employer contends that it had legitimate doubt regarding the compensability of claimant's occupational disease claim for carpal tunnel syndrome and right shoulder condition. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Essentially, the employer relies upon impeachment evidence presented at hearing as proof of legitimate doubt (i.e., claimant initially denied any prior right arm symptoms, but conceded on further cross-examination that she had been treated for unrelated right-sided arm/shoulder symptoms in 1988). (Tr. 25, 35).

We acknowledge that evidence of undivulged prior symptoms affecting a nearby body part provides some measure of legitimate doubt; however, prior to hearing that doubt was resolved in claimant's favor. Specifically, on May 10, 1993, Dr. Neufeld examined claimant at the request of the employer. (Ex. 19). Dr. Neufeld opined that claimant's work activities were responsible for her carpal tunnel syndrome, and that claimant's increased work activities may have contributed to her shoulder problems as well if her work activities had increased significantly during November and early December. (Ex. 19 at 4,5).

Notably, claimant testified that her work activities did in fact increase during November and December of each year. (Tr. 12). Claimant's supervisor corroborated that testimony. (Tr. 49). This increase in work activities precisely corresponds to the onset of claimant's right shoulder symptoms in December of 1992. (Tr. 18; Ex. 8-4).

In our prior order, we agreed with the Referee's finding that Dr. Neufeld's opinion supporting compensability of claimant's occupational disease claim removed the employer's legitimate doubt regarding the compensability of those conditions. The Referee reasoned that when Dr. Neufeld opined that claimant's carpal tunnel condition was work related, and that her right shoulder condition was similarly related to her work, contingent on increased work activities during November and December, "then the self-insured employer did not have legitimate doubt as to carpal tunnel condition and had the claims processing responsibility to determine if there was any basis to continue denying the shoulder condition." (Opinion and Order at 5).

Therefore, we continue to find the employer's denial of claimant's right shoulder and arm condition was no longer reasonable upon receipt of Dr. Neufeld's May 21, 1993 opinion.

Finally, claimant seeks an attorney fee award for services in responding to the employer's motion for reconsideration. However, since penalties and attorney fees are not "compensation" for the purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for defending such issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 13, 1994 order, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY D. DISON, Claimant
WCB Case Nos. 93-07330 & 93-07835
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee Schultz' order that: (1) affirmed an Order on Reconsideration awarding claimant 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right finger; and (2) set aside the Director's order which found claimant entitled to vocational assistance. The employer cross-requests review of that portion of the Referee's order that awarded attorney fees for the employer's allegedly unreasonable failure to comply with the Director's order. On review, the issues are extent of scheduled permanent disability, entitlement to vocational assistance, penalties and attorney fees.

We adopt and affirm the Referee's order with the following supplementation.

Vocational Assistance

We affirm that portion of the Referee's order that found claimant ineligible for vocational assistance, with the following comment.

In reaching our decision, we have considered the Supreme Court's holding in Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993). In that case, the Court held that, where the Director informally investigates and issues an order, the Referee's role is to conduct a hearing at which the parties develop a record; on the basis of that record, the Referee finds the facts from which to conclude whether, among other things, the Director's decision survives review. The Board then reviews under ORS 656.283(2) upon the record developed before the Referee. The decision of the Director may be modified only if it: (1) violates a statute or rule; (2) exceeds the Director's statutory authority; (3) is made upon an unlawful procedure; or (4) is characterized by an abuse of discretion or clearly unwarranted exercise of discretion. ORS 656.283(2).

Here, we are persuaded that the hearing before the Referee comported with the procedures required by ORS 656.283. At the hearing, the parties were allowed to develop a record. Based on that record, the Referee found facts and concluded that the Director's order was an abuse of discretion. After our review of the developed record, we agree with and adopt the Referee's conclusions and reasoning concerning claimant's ineligibility for vocational services.

Penalties and Attorney Fees

The Referee found that the employer's failure to provide vocational assistance pursuant to the May 7, 1993 Director's Review and Order was an unreasonable resistance to the payment of compensation. Consequently, the Referee found claimant entitled to an assessed attorney fee under ORS 656.382(1).

Citing Colclasure v. Washington County School Dist. No. 48-J, 117 Or App 128, 133 (1992), rev'd 317 Or 526 (1993), the employer asserts that vocational assistance benefits are stayed pending appeal from a Director's order. That decision, as well as our prior decision on review, Richard A. Colclasure, 42 Van Natta 2574 (1990), and our subsequent decision on remand, Richard A. Colclasure, 46 Van Natta 1246, 1251 (1994), applied former ORS 656.313(1) & (4), in concluding that vocational assistance awarded pursuant to an Opinion and Order was not the type of compensation required to be paid pending appeal. In other words, under former ORS 656.313(4), vocational assistance was not a form of "compensation" for purposes of the statute and, thus, was not required to be paid pending review.

Here, unlike its former version, current ORS 656.313 does not include a section which attempts to limit the definition of compensation. Inasmuch as vocational assistance constitutes a benefit provided for a compensable injury, we conclude that it is encompassed within the term "compensation." See ORS 656.005(8).

Although vocational assistance benefits are "compensation," ORS 656.313 does not authorize a carrier to stay the payment of vocational assistance benefits because the statute does not refer to carrier requests for hearing from a Director's order awarding vocational assistance benefits. We have previously ruled that "appeal" in ORS 656.313 pertains to carrier appeals from Board orders, referee orders, and requests for hearing from an Order on Reconsideration. Melvin L. Nelson, 46 Van Natta 1676 (1994). Consistent with our reasoning in Nelson, we conclude that the amended version of ORS 656.313 does not allow a carrier to stay payment of vocational assistance benfits awarded by a Director's order pending the carrier's request for hearing on that order.

Consequently, we find no authority under the statute for the employer's conduct and consider its conduct to be unreasonable. Accordingly, we agree with the Referee's assessment of an attorney fee based upon the employer's unreasonable resistance to the payment of compensation. See ORS 656.382(1). Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 13, 1993 is affirmed.

In the Matter of the Compensation of
FREDA P. WEIGLE, Claimant
WCB Case Nos. 93-13607, 93-09319, 93-13606 & 93-10996
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Robert Jackson (Saif), Defense Attorney
John E. Snarskis, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of those portions of Arbitrator Black's order that: (1) set aside its denial of claimant's occupational disease claim for claimant's upper body and extremity conditions; and (2) upheld Industrial Indemnity's denial of the same conditions. On review, the issue is responsibility.

Reviewing this case pursuant to our de novo review authority, we adopt and affirm the Arbitrator's order with the following supplementation. See ORS 656.307(2).

Standard of Review

ORS 656.307(2) provides that we review decisions rendered by an arbitrator for questions of law except in one circumstance: "[I]f the claimant can establish, on the arbitration record, that the determination [of the responsibility issue] resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator by the board * * * shall be as provided for matters concerning a claim." ORS 656.704(3) defines a matter concerning a claim as "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue."

Here, claimant did not formally request or cross-request review of the Arbitrator's responsibility determination. However, we have interpreted ORS 656.307(2) as not requiring a claimant to formally request or cross-request review. See Brenda K. Passmore, 43 Van Natta 1457 (1991). In this case, claimant filed a brief in which she asked that the Arbitrator's assignment of responsibility be reversed. In addition, the arbitration record (the order designating a paying agent under ORS 656.307) shows that the temporary disability rate will be affected by the assignment of responsibility. (Ex. 37).

Under these circumstances, claimant has invoked her right to de novo review under ORS 656.307(2). Brenda K. Passmore, supra, at 1457. Therefore, we apply the de novo standard of review.

Responsibility

SAIF argues that the Arbitrator erred in applying the Last Injurious Exposure Rule (LIER) to find it responsible for claimant's current condition, diagnosed as post-traumatic fibromyalgia, Reynaud's syndrome and postural thoracic outlet syndrome. SAIF contends that claimant's current condition relates to claimant's compensable 1989 bilateral wrist and elbow injury, for which Industrial Indemnity was responsible, because it arose as a consequence of that injury. See ORS 656.005(7)(a)(A). Thus, according to SAIF, claimant's current compensable condition "involves the same condition" determined to be compensable under the Industrial Indemnity claim. Therefore, it argues that responsibility should be determined under ORS 656.308(1). We disagree.

To answer the question of whether ORS 656.308(1) applies to this claim, we need to determine if claimant's current condition for which she seeks compensation involves the "same condition" as the prior accepted claim processed by Industrial Indemnity. See Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993). SAIF asserts that the opinion of Dr. Randle, claimant's attending physician, establishes that it is the "same condition." Dr. Randle wrote:

> "In summary, I believe that the patient's initial trauma produced long term susceptibility to overuse symptoms from her job at the mill and it is certainly possible that she would have developed some of these symptomatologies without the trauma of 1989, but I think the trauma made her much more susceptible and therefore would attribute this as the major cause. *** I feel the patient's work activities since May of 1991 have contributed their own share or their own proportion to the condition giving rise to the patient's current complaints and I think the answer to that question is yes, her work activities will contribute but again, since she was doing these activities before the trauma without significant symptomatology and then developed a significant symptomatology after the

trauma, I believe the trauma is the major contributing cause and this trauma was from December of 1989." (Ex. 36-2). (Emphasis added).

Dr. Randle does not explain how the trauma in 1989 caused claimant's current condition, other than to say that it made her more "susceptible" to overuse symptomatology in her upper extremities and upper body. In the absence of such an explanation, we agree with the Arbitrator's reasoning and conclusion that Dr. Randle's medical opinion only established that the 1989 injury with Industrial Indemnity predisposed or made claimant susceptible to developing her current upper extremity and upper body condition. Cf. Liberty Northwest v. Spurgeon, 109 Or App 566, 569 (1991) (In determining the major contributing cause of an occupational disease, susceptibility or predisposition that does not cause condition is not considered in major contributing cause calculus). Therefore, without more explanation from Dr. Randle, we do not consider claimant's 1989 injury to be a causal factor in claimant's current condition. See Elizabeth R. Kitzman, 46 Van Natta 428, 429 (1994) (unexplained medical opinion not persuasive).

Moreover, Dr. Randle's opinion is primarily based on a temporal relationship between claimant's current overuse symptomatology and the 1989 injury. For this reason as well, we do not find that Dr. Randle's opinion establishes that the 1989 injury is the major contributing cause of claimant's current condition. See Allie v. SAIF, 79 Or App 284, 288 (1986). Thus, we conclude that: (1) claimant's current condition is different from that which resulted from the compensable 1989 injury; and (2) claimant's current condition neither represents a "consequential" or "resultant" condition caused by the 1989 compensable injury with Industrial Indemnity.

In light of our aforementioned conclusions, ORS 656.308(1) is not applicable. We, therefore, agree with the Arbitrator that responsibility should be determined under LIER. See Markus M. Tipler, 46 Van Natta 1711 (1994) (current shoulder condition not the "same condition" as that which resulted from original compensable injury; responsibility determined under LIER, not ORS 656.308(1)). Finally, because Dr. Randle opined that claimant's employment after May 1991 while SAIF was on the risk actually contributed to claimant's condition, the Referee correctly determined that SAIF was responsible under LIER. Multnomah County School District v. Tigner, 113 Or App 405, 408 (1992).

ORDER

The Referee's order dated January 5, 1994 is affirmed.

In the Matter of the Compensation of
LAUREY J. KNOWLAND, Claimant
WCB Case No. 92-10800
ORDER ON REVIEW
Douglas L. Minson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Bethlahmy's order that affirmed a Director's order under ORS 656.327(2) finding back surgery inappropriate. On review, the issue is medical services.

We adopt and affirm the Referee's order with the following supplementation.

Pursuant to ORS 656.327(2), the Director's order may be modified only if it is not supported by substantial evidence in the record. Substantial evidence exists to support a finding when the record, reviewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990); Queener v. United Employers Insurance, 113 Or App 364 (1992).

In 1975, claimant compensably injured his low back. In 1982 and 1987, Dr. Nash, neurosurgeon, performed back surgery to decompress the nerve. When claimant returned to Dr. Nash in 1991 with worsened symptoms, Dr. Nash recommended a third back surgery.

The insurer denied the proposal and requested review by the Director. Dr. Nash performed the surgery in February 1992. In July 1992, the Director issued an order finding that the insurer was not required to reimburse for the surgery. The Referee concluded that substantial evidence supported the Director's order and affirmed.

We agree with the Referee that substantial evidence supports the Director's order. According to Dr. Nash, claimant's symptoms are due to the compression of a nerve by claimant's stenosis. Dr. Nash in part based his diagnosis on finding absent left hamstring reflexes; absent bilateral ankle reflex, greater on the left; and bilateral dermatomal S1 sensory losses in the feet. (Exs. 72, 28-12, 28-13).

However, there were different findings by the other examining physicians, including Dr. Berkeley, neurosurgeon who examined claimant in June 1991 at Dr. Nash's request; Dr. Noyes, who assisted Dr. Nash during the surgery; and Drs. Watson, neurologist, and Farris, orthopedic surgeon, a panel that examined claimant on behalf of the insurer. These physicians found that claimant's sensory loss in his legs were of a "stocking-like" configuration that did not follow a dermatomal distribution. (Exs. 60-1, 73-2, 18-6). Dr. Berkeley also found a normal right ankle jerk and diminished left ankle jerk while the panel found that ankle reflexes were "trace" but "distinctly present and symmetrical." (Exs. 60-1, 18-6).

Based on such findings, and claimant's diagnosed diabetes, Dr. Berkeley and the panel suggested that at least part of claimant's symptoms were due to diabetic neuropathy. (Exs. 60-1, 18-8). Drs. Watson and Farris recommended against surgery of any kind, stating that treatment should be directed to claimant's diabetes, associated vascular disease, and obesity. (Ex. 18-8).

Dr. McGirr, neurosurgeon, reviewed the records on behalf of the Director. He agreed that claimant's diabetes was a source of his symptoms and that many of the physical findings could be related to diabetic neuropathy since such a condition could mimic symptoms of a compressive nerve root syndrome. (Ex. 23-6, 23-7). Dr. McGirr further indicated that Dr. Nash had not established that claimant's symptoms were due to root involvement in view of the discrepancies in examinations. (Id. at 7). Therefore, he agreed that the surgery was not appropriate.

In view of this evidence, we find that a reasonable person could conclude that Dr. Nash's diagnosis of a compressed nerve root was not established to a medical probability. Therefore, inasmuch as the surgery was to treat only a compressed nerve and not appropriate for any other condition, such as diabetic neuropathy, we conclude that substantial evidence supports the Director's order finding that the surgery was not appropriate. See ORS 656.327(2).

ORDER

The Referee's order dated January 18, 1994 is affirmed.

September 30, 1994 Cite as 46 Van Natta 1931 (1994)

In the Matter of the Compensation of
TAMARA J. SIGLER, Claimant
WCB Case No. 91-14416
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Sigler v. A & B Automotive, 128 Or App 692 (1994). The court reversed that portion of our prior order, Tamara J. Sigler, 45 Van Natta 1201 (1993), which found that claimant was not entitled to an unscheduled permanent disability award. In reaching our conclusion, we held that a "post-reconsideration order" medical report from claimant's attending physician was not admissible. Citing Scheller v. Holly House, 125 Or App 454, 457, rev den 319 Or 36 (1994), and Safeway Stores, Inc. v. Smith, 122 Or App 160, 163 (1993), the court has remanded for reconsideration in light of the previously excluded medical report.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A Notice of Closure awarded no permanent disability for claimant's neck strain. Claimant requested reconsideration. No medical arbiter was appointed. The Order on Reconsideration affirmed the Notice of Closure. The Referee affirmed the Order on Reconsideration.

Claimant contends that she is entitled to 5 percent unscheduled permanent disability for a chronic condition which renders her unable to repetitively use the cervical/upper thoracic body area. In doing so, claimant relies on the "post-reconsideration order" medical report of her attending physician, Dr. Takacs. (Ex. 26).

On review, we concluded that Dr. Takacs' "post-reconsideration order" medical report was not admissible. Tamara J. Sigler, supra. Inasmuch as the excluded report was the basis for claimant's permanent disability award, we held that claimant was not entitled to such an award. Consequently, we affirmed the Referee's order.

The court has reversed our decision. Sigler v. A & B Automotive, supra. Noting that no medical arbiter was appointed, the court concluded that the "post-reconsideration order" medical report is admissible. Consequently, the court has remanded for reconsideration. In accordance with the court's mandate, we proceed with our reconsideration.

In order to be entitled to unscheduled chronic condition impairment, the medical evidence must establish that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. OAR 436-35-320(5). We have interpreted this rule as requiring medical evidence of at least a partial loss of ability to repetitively use a body part. Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452, 1453 (1993).

ORS 656.295(5) directs the Board to evaluate a worker's permanent disability as of the time of the reconsideration order. We have interpreted a similar provision in ORS 656.283(7) as designating a point in time at which a worker's permanent disability is evaluated. Gary C. Fischer, 46 Van Natta 60, 62 (1994). Medical evidence that is generated after the date of the reconsideration order, but which addresses a worker's permanent impairment as of the date of the reconsideration order is relevant and material evidence under ORS 656.283(7) and 656.295(5). Scheller v. Holly House, supra; Gary C. Fischer, supra.

Here, Dr. Takacs, claimant's treating physician, generated a report after the Order on Reconsideration in which he concurred with the statement that claimant is unable to repetitively use her cervical/thoracic body area due to her compensable neck strain. To his "check-the-box" concurrence he added the explanation, referring to prior chart notes, that claimant has been unable to perform her prior work as a tow truck driver due to "pain, spasm, and decreased range of motion in the neck," despite earnest attempts to do so. (Ex. 26).

The insurer contends that Dr. Takacs' opinion does not support a chronic condition award because it is conclusory and unsupported by objective findings. We disagree.

Dr. Takacs relies on his prior chart notes as the basis for his conclusion that claimant is unable to repetitively use her cervical/thoracic body area. We first note that, inasmuch as the chart notes were generated between April 1991 and October 1991, they are relevant and material to evaluating the extent of claimant's impairment as of the date of the Reconsideration Order, October 15, 1991. (Ex. 24).

Those records show that, beginning in April 1991, Dr. Takacs attributed the resolution of claimant's cervical/thoracic symptoms to avoiding the "rather arduous" work of tow truck driving. (Ex. 17). However, when claimant attempted to perform physically strenuous work, such as gardening or tow truck driving, she developed intense muscle spasms, severe neck pain and difficulty rotating her neck to look over her shoulder. (Exs. 21-1, 22, 23).

Although in April 1991, Dr. Takacs declared claimant medically stationary with full range of cervical motion and no permanent impairment, he noted at the same time that claimant "may have a slightly decreased functional capacity as a result of [the] injury." (Exs. 16, 17). At that time, he attributed claimant's "complete relief of symptomatology" in part to no longer working as a tow truck driver. (Exs. 17, 25). However, Dr. Takacs also hypothesized that claimant's condition would not have completely resolved had she continued with her tow truck job. (Id).

Over time, however, as claimant attempted more strenuous work activities, Dr. Takacs noted that she developed persistent upper back and neck spasms, with limitations on rotating and bending her neck. (Exs. 21-1, 22). Finally, in October 1991, Dr. Takacs noted that claimant had returned to her tow truck driver occupation out of economic necessity. At that time, physical examination revealed a palpable muscular "knot" in the right side of the neck, as well as decreased range of motion and difficulty rotating the neck. (Ex. 23). Based on these earlier chart notes, Dr. Takacs ultimately concluded that claimant was unable to repetitively use her neck and upper back. (Ex. 26).

Considering the evolving context of Dr. Takacs' opinion, we find his April 1991 opinion to be consistent with his later chart notes and his "post-reconsideration order" opinion. In particular, we note that Dr. Takacs anticipated some decreased functional capacity even in April 1991 when claimant was not engaged in any strenuous physical activities, while his subsequent chart notes document claimant's physical difficulties when she attempted more strenuous work.

We conclude that Dr. Takacs' explanation of his opinion, coupled with his earlier chart notes, adequately and persuasively explains the basis for his conclusion. In addition, we find that Dr. Takacs' conclusion that claimant has permanent impairment is established by medical evidence supported by objective findings of muscle spasms, "knots" and reduced range of motion. (See Exs. 21-1, 22, 23).

The insurer also contends that claimant is not entitled to a chronic condition award because there is no medical evidence of any other impairment. We disagree.

We have previously held, interpreting former OAR 436-35-320(1) (WCD Admin. Order 7-1988, effective January 1, 1989), that nothing in that section indicated that a medically verified loss of repetitive use is not a measurable impairment. See Robert L. Todd, 43 Van Natta 418, 419 (1991). In Todd, we concluded that loss of repetitive use is a "measurable impairment" within the meaning of former OAR 436-35-270(2). We find nothing in the April 1, 1991 disability standards that requires a different result. See former OAR 436-35-005(5); 436-35-270(2); 436-35-320.

Because our order awards additional permanent partial disability compensation, claimant's counsel is entitled to an "out-of-compensation" attorney fee equal to 25 percent of claimant's increased permanent disability, not to exceed $3,800. ORS 656.386(2); OAR 438-15-055(1). This attorney fee represents claimant's counsel's award for services at hearing and on Board review.

In addition, claimant is entitled to a reasonable attorney fee award before every prior forum for finally prevailing on the extent of unscheduled permanent disability issue. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services before the court concerning the extent of unscheduled permanent disability issue is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration of our June 28, 1993 order, the Referee's order dated January 13, 1992 is modified. Claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for her cervical/thoracic injury. Claimant's counsel is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. Claimant's counsel is awarded an assessed fee of $2,000 for services before the court, to be paid by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARCIA M. THOMAS, Claimant
WCB Case No. 93-09583
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Neal's order which: (1) affirmed an Order on Reconsideration that awarded 37 percent (118.4 degrees) unscheduled permanent disability for a low back condition; (2) declined to award claimant permanent total disability; and (3) declined to assess a penalty or attorney fee for the insurer's alleged failure to provide discovery. On review, the issues are extent of unscheduled permanent disability, including permanent total disability, and penalties and attorney fees.

We adopt and affirm the Referee's order with the following supplementation.

Permanent Total Disability/Extent of Unscheduled Permanent Disability

We adopt and affirm that portion of the Referee's order which declined to award claimant permanent and total disability.

Regarding the extent of unscheduled permanent partial disability for her low back condition, claimant disputes only the value for training. Former OAR 436-35-300(5) (WCD Admin. Order 6-1992, effective March 13, 1992). The Referee assigned a value of zero for training, because claimant has a Certified Nurses' Aide license. Claimant contends that she is entitled to a value of +1 for training because she is physically unable to work as a nurse's aide due to her compensable injury.

Under former OAR 436-35-300(5), claimant is entitled to a value of +1 for training if she has not achieved an SVP of 5 or higher in the 10 years preceding determination, and if she does not hold a "current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less."

Claimant holds a nurses' aide certificate. (Ex. 111-5). The SVP for that occupation is 4. (Id). Claimant does not contend that her certificate is no longer current, or that a nurses' aide certificate is not necessary for employment in Oregon. Compare Edwin H. Slater, 45 Van Natta 1541 (1993) ("operator training course" certificate not necessary for employment; training value allowed); Erasmo N. Aguilar, 46 Van Natta 995, 996 (1994) (no proof that foreign certificate still current or that it is necessary for job in Oregon; training value allowed).

The Director's rule does not provide for a value for training on the basis that claimant is physically unable to perform the job for which she has a certificate, due to a compensable injury. That is claimant's sole argument in support of a value for training. Under these circumstances, we find that claimant is not entitled to a value of +1 for training. Former OAR 436-35-300(5).

Penalties/Attorney Fees

We also adopt and affirm that portion of the Referee's order which declined to assess a penalty or attorney fee for the insurer's failure to disclose certain documents, with the following supplementation.

The documents consisted of physical restriction evaluations of certain jobs, obtained by the insurer's vocational expert, Ms. Howard, from Dr. Dineen, member of a panel that examined claimant in May 1993. (Tr. at 111-113). The insurer never had these reports in its possession. (Tr. at 112). Therefore, the insurer's obligation to promptly disclose all documents pertaining to a claim, pursuant to OAR 438-07-015, was not triggered.

In addition, we agree with the Referee's determination that the insurer's failure to obtain these documents was not unreasonable. See Vernon E. Lipscomb, 45 Van Natta 1132, 1135 (1993) (employer not obliged to seek out additional medical documents if it believes the submitted records are complete). Accordingly, we agree with the Referee that claimant is not entitled to a penalty or attorney fee for the alleged discovery violation.

ORDER

The Referee's order dated November 17, 1993 is affirmed.

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Cite as 319 Or 225 (1994) June 23, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Robert L. Wells, Claimant.

RONALD **ASTLEFORD**, Respondent on Review,
v.
SAIF CORPORATION, Petitioner on Review, and TILLAMOOK COUNTY CREAMERY ASSOCIATION and ROBERT L. WELLS, Respondents, and DEPARTMENT OF INSURANCE AND FINANCE, Intervenor.
(WCB 90-18739, 90-19654; CA A75105; SC S40854)

In Banc
On review from the Court of Appeals.*
Argued and submitted March 10, 1994.
Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for petitioner on review. With him on the petition were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
William J. Blitz, of Employers Defense Counsel, Eugene, argued the cause for respondent on review. David O. Wilson filed the response to the petition.
GRABER, J.
The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is vacated insofar as it approved the disputed claim settlement agreement and is otherwise affirmed. The case is remanded to the Workers' Compensation Board for further proceedings.
*Judicial review from the Workers' Compensation Board. 122 Or App 432, 858 P2d 877 (1993).

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319 Or 228> The question in this workers' compensation case is whether, under ORS 656.289(4) (set out in full below), an employer who has not complied with the provisions of the Workers' Compensation Law, ORS chapter 656, is a "party" who "may * * * by agreement" settle a disputed workers' compensation claim. We answer that question "yes."

In September 1988, claimant injured his left shoulder. He filed a workers' compensation claim. In December 1988, the Department of Insurance and Finance[1] (DIF) entered a proposed order, pursuant to ORS 656.052(2), declaring that claimant's employer, Ronald Astleford (Employer), was a noncomplying employer. Employer did not contest the proposed order within the 20-day period provided by ORS 656.740. Pursuant to ORS 656.054(1), DIF referred the claim to the State Accident Insurance Fund Corporation (SAIF), which accepted it and notified Employer of its right to request a hearing. Employer did not request a hearing. Later, however, Employer issued a notice to claimant disclaiming responsibility for claimant's injury, on the ground that Tillamook County Creamery Association (TCCA) was the responsible employer. Claimant requested a hearing. In November 1990, SAIF denied compensability of claimant's left shoulder injury. Claimant requested a hearing on that denial.

In July 1990, while still working for Employer, claimant injured his left hand. He filed a new workers' compensation claim for that injury. In September 1990, SAIF denied the claim. Claimant requested a hearing on that denial also. At the time of the 1990 injury, Employer still was noncomplying.

The referee consolidated the two claims for hearing. Employer filed a motion to join TCCA and SAIF, again asserting that TCCA was the responsible employer. The referee issued an order denying the motion. Pursuant to ORS 656.289(4), claimant, DIF, and SAIF then entered into a disputed claim settlement (DCS) agreement awarding claimant $28,000. Consistent with the terms of the DCS agreement, claimant and SAIF filed a motion to dismiss both of **<319 Or 228/229>** claimant's requests for hearings. The referee approved the DCS agreement and dismissed claimant's requests for hearings.

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[1] That department later was renamed the Department of Consumer and Business Services.

Pursuant to ORS 656.295, Employer appealed to the Board. Employer argued that the referee erred in denying his motion to join TCCA and SAIF in the claim and that, as a "party" within the meaning of ORS 656.005(20), Employer was entitled, under ORS 656.289(4), to participate in the making of the DCS agreement. The Board by final order affirmed the referee's holdings, which approved the DCS agreement, dismissed claimant's requests for hearings, and denied Employer's motion.

Employer then filed a petition for judicial review of the Board's final order pursuant to ORS 656.298. Employer argued that the Board erred in not remanding the case for a hearing to determine his status as a noncomplying employer. In the alternative, Employer again argued that, under ORS 656.289(4), he was a party who was entitled to participate in the making of the DCS agreement.

The Court of Appeals held that the Board did not err in denying Employer's request for a remand, because Employer had failed to exercise in a timely manner his right to a hearing on the issue of his status as a noncomplying employer. *Astleford v. SAIF*, 122 Or App 432, 435-36, 858 P2d 877 (1993).[2] The Court of Appeals concluded, however, that the term "parties" in ORS 656.289(4) includes a noncomplying employer and that, as a result, Employer was entitled to participate in the making of the DCS agreement. *Id.* at 436-39. The court vacated the portion of the Board's order approving the DCS agreement and affirmed the remainder of the Board's order. *Id.* at 439.

319 Or 230> SAIF petitioned this court for review of that part of the Court of Appeals' decision vacating the DCS agreement.[3] We allowed SAIF's petition and now affirm the decision of the Court of Appeals.

This court has not previously considered whether, under ORS 656.289(4), a noncomplying employer is a "party" who "may * * * by agreement" settle a disputed workers' compensation claim. In interpreting a statute, the court's task is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The best evidence of the legislature's intent is the text of the statute. *Id.* at 610-11. Also at the first level of analysis, the court considers the context of the statutory provision at issue, including other provisions of the same statute and other statutes relating to the same subject. *Ibid.* If the intent of the legislature is not clear from the text and context of the statute, the court considers the legislative history of the statute. *Id.* at 611-12. If the intent of the legislature remains unclear after the completion of the foregoing inquiries, the court may resort to general maxims of statutory construction for assistance in resolving the remaining uncertainty. *Id.* at 612.

ORS 656.289(4) provides:

> "Notwithstanding ORS 656.236 [relating to disposition by the parties of matters other than medical services], in any case where there is a bona fide dispute over compensability of a claim, *the parties may*, with approval of a referee, the board or the court, *by agreement make such disposition of the claim as is considered reasonable.*" (Emphasis added.)

ORS 656.289(4) does not inform us expressly whether a noncomplying employer is a "party" who is entitled to participate in the making of a DCS agreement.

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[2] The Court of Appeals reasoned, in part:

> "Employer first argues that the Board erred in refusing to remand for a hearing on his ORS 656.029 argument. That argument, in essence, is that he was not a noncomplying employer. * * *
>
> "When DIF issued the order declaring employer to be a noncomplying employer, it notified him of the right to request a hearing. Had employer timely exercised that right, the issue that he claims should be determined on remand would have been decided at that time. He did not. Consequently, the order became final, and neither the board nor we can review it." 122 Or App at 435-36.

[3] Employer petitioned this court for review of the Court of Appeals' decision in respect to the Board's denial of Employer's request for a remand, quoted in note 2, above. This court did not allow review of that issue.

The Workers' Compensation Law contains a general definition section, however. *See* ORS 656.005 (providing definitions for the Workers' Compensation Law). In addition, ORS 656.003 provides that "the definitions given in this chapter govern its construction," "*[e]xcept where the context* **<319 Or 230/231>** *otherwise requires.*" (Emphasis added.) We therefore next examine the definitions provided for the chapter and then consider whether "the context * * * requires" that they not govern in the circumstances presented here.

ORS 656.005(20) defines a "party" as

> "a claimant for compensation, *the employer of the injured worker at the time of the injury* and the insurer, if any, of such employer." (Emphasis added.)

That definition informs us that the term "parties" in ORS 656.289(4) includes "employers." Various provisions of the Workers' Compensation Law inform us as to the meaning of the term "employer." ORS 656.005(13) defines "employer" as

> "any person * * * who contracts to pay a remuneration for and secures a right to direct and control the services of any person."

ORS 656.005(25) defines "subject employer" as

> "an employer who is subject to this chapter as provided by ORS 656.023."

ORS 656.023 provides:

> "Every employer employing one or more subject workers[4] in the state is subject to this chapter."

Finally, ORS 656.005(18) defines "noncomplying employer" as

> "a subject employer who has failed to comply with ORS 656.017 [setting out methods of maintaining workers' compensation insurance]."

Taken together, the foregoing statutory definitions suggest that the term "employer," as used in ORS chapter 656, has a broad meaning encompassing all persons, whether or not they comply with the requirements of the Workers' Compensation Law, who "contract[] to pay a remuneration for and secure[] a right to direct and control the services of any person" who is a "subject worker" within the meaning of **<319 Or 231/232>** the chapter. Because claimant in this case is a subject worker within the meaning of ORS chapter 656 and because Employer contracted to pay remuneration to claimant and secured a right to direct and control his services, Employer, although noncomplying, appears to be an "employer" within the meaning of ORS chapter 656. As a result, Employer also appears to be a "party" within the general meaning of that chapter.

In accordance with ORS 656.003, quoted above, we next inquire whether "the context * * * requires" that the term "parties" in ORS 656.289(4) be given a different meaning than the one suggested by the general definition of "party" in ORS chapter 656. In order to conduct that inquiry, we must consider how restrictive a test the legislature intended when it provided in ORS 656.003 that the listed definitions apply "[e]xcept where the context otherwise requires."

This court applied that exception clause of ORS 656.003 in *SAIF v. Stephen*, 308 Or 41, 774 P2d 1103 (1989), a workers' compensation case. In *Stephen*, the court was called on to decide whether the claimant was a "worker" within the meaning of a particular provision of the Workers' Compensation Law, even though she did not fit the statutory definition of that term. Noting that the statutory definitions provided in that act apply "except where the context otherwise requires," ORS 656.003, the court examined the structure and purpose of the workers' compensation statutes to arrive at an answer that best comported with the legislative intent of the scheme as a whole. The court concluded that the claimant was a worker within the meaning of the provision at issue.

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[4] ORS 656.005(26) defines "subject worker" as "a worker who is subject to this chapter as provided by ORS 656.027." ORS 656.027 provides that "[a]ll workers are subject to this chapter," except certain described categories of nonsubject workers, none of which is relevant here.

With respect to ORS 656.003, this court implicitly concluded in *SAIF v. Stephen, supra,* that the legislature did not seek uniformity of definitions unless a different definition is *compelled,* but rather sought uniformity only so far as it is *appropriate* to the sensible functioning of the workers' compensation system as a whole. *See* Webster's Third New Int'l Dictionary 1929 (unabridged ed 1993) ("require" means, among other things, "to call for as suitable or appropriate in a particular case"). *See also Stephens v. Bohlman,* 314 Or 344, 350 n 6, 838 P2d 600 (1992) (when Supreme Court construes **<319 Or 232/233>** a statute, that construction becomes part of the statute). Thus, under ORS 656.003, "the context * * * requires" that a given statutory definition not apply when the context -- including the structure and purpose of the workers' compensation scheme as a whole -- demonstrates that the use of that given definition would be inappropriate, because the result of such use would conflict with one or more aspects of that structure or purpose. We proceed to apply that standard to the question at hand.

The context of ORS 656.289(4) includes other sections of the same statute and provisions of related statutes. One related statute, ORS 656.283, describes hearing procedures, and it uses the term "party" several times. For example, under ORS 656.283(1), "any party * * * may at any time request a hearing on any question concerning a claim." ORS 656.283(3) explains how a "party" makes the request for a hearing, and ORS 656.283(5) requires notice "to all parties in interest." ORS 656.283(8) allows "[a]ny party" to issue and serve subpoenas. Other sections of ORS 656.289, which also relates generally to hearings and dispute resolution, likewise use the term "party." ORS 656.289(1) provides that, "[u]pon the conclusion of any hearing, or prior thereto with concurrence of the parties," the referee shall make a decision and issue an order within specified time limits. ORS 656.289(2) provides that a copy of the referee's order shall be sent "to all parties in interest." ORS 656.289(3) allows a "party" to request review by the Board.

There is no indication that the legislature intended the term "party" to have a different meaning in ORS 656.289(4) than it has in the other sections of ORS 656.289 and in related statutes. SAIF does not suggest any reason why the term "party" in ORS 656.289(1), (2), and (3) and in ORS 656.283 has other than the statutory meaning provided in ORS 656.005(2), and we can think of none.

SAIF argues, however, that the definition in ORS 656.005(2), if applied to ORS 656.289(4), would conflict with aspects of the purpose of the workers' compensation scheme as a whole. It points to the legislative policies expressed in ORS 656.012(2)(b) and (c): to provide an administrative system that "reduces litigation and eliminates the adversary nature of the compensation proceedings" and "[t]o restore **<319 Or 233/234>** the injured worker physically and economically to a self-sufficient status in an expeditious manner." It also points to provisions making SAIF the insurer with respect to employees of noncomplying employers, providing that claims against noncomplying employers are to be processed the same way as claims against insured employers, and granting workers' compensation insurers the authority to process claim for their insureds. ORS 656.054(1); 656.262(1). Finally, it points to the legislative policies embodied in ORS 656.576 to 656.596: to deny to noncomplying employers some of the protections afforded to complying employers under the Workers' Compensation Law and to give the paying agency the dominant role in the process of disposing of a claim by a worker against a noncomplying employer.

Those provisions are not sufficient to overcome the statutory definition of "party." The provisions of ORS 656.012(2) are general and hortatory in nature. The provisions of ORS 656.054(1) and 656.262(1) say nothing about the statutory rights of either complying or noncomplying employers to participate in the making of a DCS agreement. Finally, the provisions of ORS 656.576 to 656.596, although generally to the benefit of SAIF and injured workers vis-a-vis noncomplying employers, are not inconsistent with the use of the statutory definition of "party," ORS 656.005(20), in ORS 656.289(4). Put differently, either the statutory definition or SAIF's proposed definition of the term "party" would be consistent with the purposes of ORS 656.576 to 656.596.

We conclude, therefore, that the statutory definition of "party" in ORS 656.005(20) applies to ORS 656.289(4). Under ORS 656.289(4), a noncomplying employer is a "party" who "may * * * by agreement make such disposition of the claim as is considered reasonable."

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is vacated insofar as it approved the disputed claim settlement agreement and is otherwise affirmed. The case is remanded to the Workers' Compensation Board for further proceedings.

Cite as 319 Or 235 (1994) June 23, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Jerry B. Mathel, Claimant.

JERRY B. **MATHEL**, Petitioner on Review,
v.
JOSEPHINE COUNTY, Respondent on Review.
(WCB 90-18752; CA A76236; SC S40735)

On review from the Court of Appeals.*

Argued and submitted May 9, 1994.

Michael M. Bruce, of Rasmussen & Henry, Eugene, argued the cause for petitioner on review. With him on the petition was Eveleen Henry.

Michael G. Bostwick, of Bostwick, Sheridan & Bronstein, Portland, argued the cause and filed a response for respondent on review.

James S. Coon and Susan Dobrof, of Royce, Swanson, Thomas & Coon, Portland, filed a brief on behalf of amicus curiae Oregon Workers' Compensation Attorneys.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Unis, and Graber, Justices.

GRABER, J.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for further proceedings.

*Judicial review from the Workers' Compensation Board. 122 Or App 424, 858 P2d 450 (1993).

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319 Or 237> This case involves the interpretation of provisions of the Workers' Compensation Law, ORS chapter 656, relating to types of compensable claims. Claimant is a corrections officer at the Josephine County jail. He had hypertension, which had been under control for many years. On August 23, 1990, after experiencing two days of abnormally high stress at work, claimant suffered an episode of acute hypertension culminating in a myocardial infarction (heart attack). He filed a workers' compensation claim. His employer denied the claim.

After a hearing, the referee found that claimant's heart attack was caused by acute hypertension and that "claimant's job-related stress was a material contributing cause" of his hypertension. The referee concluded that claimant's hypertension and resulting heart attack constituted a compensable injury. The Workers' Compensation Board initially affirmed the referee's order.

Thereafter, however, the Court of Appeals decided *SAIF v. Hukari*, 113 Or App 475, 833 P2d 1307, *rev den* 314 Or 391 (1992). In *Hukari*, the Court of Appeals held that, under the 1987 amendments to the Workers' Compensation Law,

> "*any* claim that a condition is *independently compensable* because it was *caused by on-the-job stress*, regardless of the suddenness of the onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as a claim for an occupational disease under ORS 656.802." *Id.* at 480 (emphasis in original).

Relying on the Court of Appeals' decision in *Hukari*, the Workers' Compensation Board reconsidered claimant's case and reversed its initial decision. The Board concluded that the claim must be analyzed under ORS 656.802 and that, because claimant did not have a diagnosed mental disorder as required by ORS 656.802(3)(c), the claim was not compensable.

Claimant petitioned for judicial review. The Court of Appeals, sitting *in banc*, affirmed the Board's order on reconsideration. *Mathel v. Josephine County*, 122 Or App 424, 858 **<319 Or 237/238>** P2d 450 (1993). We allowed claimant's petition for review and now reverse the decision of the Court of Appeals.

ORS 656.005(7)(a) provides:

"A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

"(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

ORS 656.802 provides:

"(1) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"(a) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.

"(b) Any mental disorder which requires medical services or results in physical or mental disability or death.

"(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death.

"(2) The worker must prove that employment conditions were the major contributing cause of the disease or its worsening. * * *

"(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:

319 Or 239> "(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

"(b) Unless the employment conditions producing the mental disorder are conditions other than the conditions generally inherent in every working situation or reasonable disciplinary, corrective, or job performance evaluation actions by the employer, or cessation of employment.

"(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."[1]

It is not disputed on review that claimant established his case by medical evidence supported by objective findings and that he met the requirements of ORS 656.005(7)(a)(A) and (B), set out above. What is at issue is whether claimant's heart attack properly is analyzed as an accidental injury under that statute or, instead, must be analyzed under ORS 656.802, relating to occupational diseases, including mental disorders.

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[1] We agree with the majority below that 1990 amendments to ORS 656.802 do not affect the analysis of the question before us; the introductory phrase and the wording of paragraph (1)(b) remain the same.

In interpreting a statute, the court's task is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The best evidence of the legislature's intent is the text of the statute. *Id.* at 610-11. In reading the text, the court uses relevant rules of construction, such as the rule that words of common usage typically should be given their ordinary meaning. *Id.* at 611. Also at the first level of analysis, the court considers the context of the statutory provision at issue, including other provisions of the same statute and other statutes relating to the same subject. *Ibid.* If the intent of the legislature is not clear from the text and context of the statute, the court considers the legislative history of the statute. *Id.* at 611-12. If the intent of the legislature remains unclear after the completion of the foregoing inquiries, the court may resort to general maxims of statutory construction for assistance in resolving the remaining uncertainty. *Id.* at 612. Also relevant **<319 Or 239/240>** in this case is the principle that, when the Supreme Court has construed a statute, that construction becomes part of the statute. *Stephens v. Bohlman*, 314 Or 344, 350 n 6, 838 P2d 600 (1992).

The Workers' Compensation Law does not define the terms "injury" or "disease." The ordinary meaning of the term "injury" is "an act that damages, harms, or hurts"; "hurt, damage, or loss sustained." Webster's Third New Int'l Dictionary 1164 (unabridged ed 1993). The ordinary meaning of the term "disease" is "an impairment of the normal state of the * * * body"; "sickness, illness." *Id.* at 648. "Sickness" is defined in part as "the condition of being ill." *Id.* at 2111. "Illness" is defined in part as "an unhealthy condition of the body or mind." *Id.* at 1127. The foregoing definitions suggest that a heart attack is an "injury," because it is an event, as distinct from an ongoing condition or state of the body or mind.

That conclusion is consistent with this court's decision in *James v. SAIF*, 290 Or 343, 614 P2d 565 (1981). In that case, this court considered the difference between "injury" and "disease" under the Workers' Compensation Law and adopted the following distinction:

> "'What set[s] occupational diseases apart from accidental injuries [is] * * * the fact that they [are] gradual rather than sudden in onset. * * *'" *Id.* at 348 (quoting 1B Larson's Workmen's Compensation Law 41.31 as cited in *O'Neal v. Sisters of Providence*, 22 Or App 9, 537 P2d 580 (1975)).

A heart attack likewise fits the criterion of sudden onset.

More particularly, this court's previous cases have treated heart attacks arising from *physical exertion* as "injuries" within the meaning of the Workers' Compensation Law for over 30 years. In *Olson v. State Ind. Acc. Com.*, 222 Or 407, 352 P2d 1096 (1960), this court considered whether the deceased worker's heart attack was a compensable injury under the 1957 amendments to the statute. The worker was a jackhammer operator who suffered a fatal heart attack while operating that tool. *Id.* at 409. His widow sought workers' compensation benefits. The trial court found in her favor, and this court affirmed. *Id.* at 410, 416.

319 Or 241> The court examined the extant statutory provisions. Under ORS 656.202(1) (1959), a worker was entitled to compensation if the worker "sustain[ed] an accidental injury arising out of and in the course of his employment." ORS 656.002(19) (1959) provided that "[a]n injury is accidental if the result is an accident, whether or not due to accidental means." Applying those provisions, the court held that "any workman who undesignedly and unexpectedly suffer[s] a hurt, without reference to whether the cause of the injury itself was accidental," meets the requirement of an "accidental" injury. *Olson v. State Ind. Acc. Com., supra*, 222 Or at 413. Under that test, the accidental element of the statute was satisfied in that case, because the worker "did not intend his sudden death, it was not expected nor designed, but was an unlooked for and unexpected event." *Id.* at 414 (emphasis added). The court also concluded that there was evidence from which the trier of fact properly could determine that the worker's work "contributed to the injury which led to his death." *Id.* at 416. Therefore, the heart attack was compensable. *Ibid.*

The provisions of the Workers' Compensation Law that this court construed in *Olson v. State Ind. Acc. Com., supra*, remain unchanged. Thus, this court's previous interpretation of those provisions also suggests that a heart attack arising out of and in the course of employment -- at least one caused by physical exertion -- is an accidental injury.

Claimant's heart attack, however, purportedly was caused by stress, rather than by physical exertion. This court has not previously considered how to categorize that kind of claim.

As stated, in *SAIF v. Hukari, supra,* the Court of Appeals held that "any claim that a condition is independently compensable because it was caused by on-the-job stress" must be considered as a claim for a mental disorder under the post-1987 occupational disease statute, ORS 656.802, quoted in part above. In the present case, the Court of Appeals applied that interpretation to a heart attack caused by job stress. *Mathel v. Josephine County, supra.*

We conclude that the Court of Appeals erred in so holding. As explained above, we interpret the text of ORS <319 Or 241/242> 656.005(7)(a), relating to "compensable injury," as referring to events, and we interpret the text of ORS 656.802, relating to "occupational disease," as referring to ongoing conditions or states of the body or mind. As also previously explained, a heart attack is an event. Accordingly, a heart attack, including one precipitated by job stress, is an "injury" within the meaning of ORS 656.005(7).

Our conclusion in that regard is supported by the statutory context. Under the Workers' Compensation Law as a whole -- that is, with respect to both "injury" claims and "occupational disease" claims -- workers make claims for *accidental injuries* or *occupational diseases*, not for the *causes* of those accidental injuries or occupational diseases. *See* ORS 656.005(7)(a) (providing in part that a "compensable injury" is an accidental injury meeting certain criteria); ORS 656.802 (providing in part that an "occupational disease" is a disease or infection meeting certain criteria). Some provisions of the Workers' Compensation Law expressly describe certain causes, which are differentiated from the concepts of "compensable injury" and "occupational disease." *See* ORS 656.005(7)(b) ("compensable injury" does not include injuries caused by various activities such as consumption of alcoholic beverages); ORS 656.802(1)(a) ("occupational disease" includes diseases or infections caused by ingestion, absorption or inhalation of, or contact with, various substances).

Because the text and context of the statute, as well as this court's prior interpretations of relevant portions thereof, make the legislative intent clear, we do not consider legislative history or other aids to construction. *See PGE v. Bureau of Labor and Industries, supra,* 317 Or at 610-12 (discussing method of analysis).

We hold that a heart attack, whether it is caused by physical exertion, by job stress, or by both, is an accidental injury within the meaning of ORS 656.005(7). A heart attack is not a "mental disorder"[2] within the meaning of ORS <319 Or 242/243> 656.802. Accordingly, the requirements relating to mental disorders established in ORS 656.802(3) do not apply to a claim for compensation for a heart attack.

In this case, claimant sought compensation for a heart attack. Claimant's heart attack is compensable if he meets the statutory requirements for accidental injuries. The cause of claimant's heart attack -- whether physical exertion, non-physical factors, or a combination thereof -- is immaterial to the requirement that his claim be analyzed as an allegedly compensable accidental injury.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for further proceedings.

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[2] We need not arrive at a comprehensive definition of "mental disorder" to resolve this case. ORS chapter 656 does not define the term. We use it in its ordinary sense. *See* Webster's Third New Int'l Dictionary 1411 (unabridged ed 1993) ("mental" means "of or relating to the mind"; "relating to the total emotional and intellectual response of an organism to its environment"; "of, relating to, or affected by * * * psychiatric disorders"); *id.* at 652 ("disorder" means "an abnormal * * * condition"; "ailment"). *See also* Diagnostic and Statistical Manual of Mental Disorders xxii (3d ed (revised) 1987) (explaining that "no definition adequately specifies precise boundaries for the concept 'mental disorder'" but that, in that reference work, a mental disorder "is conceptualized as a clinically significant behavioral or psychological syndrome or pattern * * * that is associated with present distress * * * or disability" and that is not "merely an expectable response to a particular event").

Cite as 319 Or 244 (1994) June 23, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Michelle K. DiBrito, Claimant.

MICHELLE K. **DIBRITO**, Petitioner on Review,
v.
SAIF CORPORATION and ADULT AND FAMILY SERVICES DIVISION, Respondents on Review.
(WCB 92-13969; CA A78740; SC S40909)

On review from the Court of Appeals.*

Argued and submitted May 9, 1994.

Robert F. Webber, of Black, Chapman & Webber, Medford, argued the cause and filed the petition for petitioner on review.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the response were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Unis, and Graber, Justices.

GRABER, J.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for further proceedings.

*Judicial review from the Workers' Compensation Board. 124 Or App 680, 865 P2d 1341 (1993).

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319 Or 246> In this case we are called on to apply provisions of the Workers' Compensation Law relating to types of claims for compensation.[1] Claimant was a caseworker for Adult and Family Services. She suffered from preexisting colitis and a preexisting personality disorder. Because of health problems, claimant sought to reduce her daily work hours by half and to take the remaining half as leave without pay. Claimant became upset during a meeting with her supervisor on May 14, 1991, during which she was informed that she would not be able to retain her status as a full-time employee if her request to work part-time were granted. Claimant experienced an episode of colitis requiring medical treatment and experienced psychological symptoms.

Claimant filed a workers' compensation claim for her physical and mental conditions,[2] which her employer's insurer, SAIF Corporation (SAIF), denied. After a hearing, the referee concluded that claimant had suffered a compensable accidental injury under ORS 656.702, because she proved that "the events of May 14 were a material contributing cause of [her] need for medical treatment" for colitis. The referee concluded, however, that claimant did not suffer a compensable occupational disease under ORS 656.802(3), relating to mental disorders, because "the stressful events [of the May 14 meeting] did not cause or worsen her psychiatric diagnosis."

SAIF appealed to the Workers' Compensation Board (Board). Relying on *SAIF v. Hukari*, 113 Or App 475, 833 P2d 1307, *rev den* 314 Or 391 (1992), which was decided after the referee issued his order in this matter,[3] the Board concluded **<319 Or 246/247>** "that the claim is one for a stress-caused physical condition, which must fall within ORS 656.802(1)(b) in order to be compensable." On review of the record, the Board determined that "claimant's psychological condition was due, in major part, to factors other than work conditions" and that, "[a]ccordingly, neither claimant's mental condition nor her physical symptoms resulting from on-the-job stress are compensable."

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[1] The relevant provisions are set out at notes 4 and 5, below.

[2] On her claim form, claimant described her "injury or disease" as "Mental Stress/Physical."

[3] In *SAIF v. Hukari*, 113 Or App 475, 480, 833 P2d 1307, *rev den* 314 Or 391 (1992), the Court of Appeals held that, under the 1987 amendments to the Workers' Compensation Law,

> "*any* claim that a condition is *independently compensable* because it was *caused by on-the-job stress*, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as a claim for an occupational disease under ORS 656.802." (Emphasis in original.)

Claimant sought judicial review in the Court of Appeals, which affirmed the Board's order without opinion. *Dibrito v. SAIF*, 124 Or App 680, 865 P2d 1341 (1993). We allowed review and now reverse the decision of the Court of Appeals, reverse the order of the Board, and remand the case to the Board.

In *Mathel v. Josephine County*, 319 Or 235, ___ P2d ____ (1994), we considered whether a claim for a heart attack precipitated by "job stress" properly is analyzed under ORS 656.005(7),[4] relating to compensable accidental injuries, or under ORS 656.802,[5] relating to occupational diseases, **<319 Or 247/248>** including mental disorders. We examined the text and context of those statutes and this court's prior interpretations of them. *Id.* at 239-42. We noted that, although some provisions of the Workers' Compensation Law describe certain causes of accidental injuries or occupational diseases, workers make claims for the latter, not for their causes. *Id.* at 242. We concluded that ORS 656.005(7), relating to compensable injuries, refers to "events" and that ORS 656.802, relating to occupational diseases, including mental disorders, refers to "ongoing conditions or states of the body or mind." *Ibid.* We held that a heart attack is an "event," *ibid.*, and that, accordingly,

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[4] ORS 656.005(7) provides in part:

"(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

"(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

[5] ORS 656.802 provides:

"(1) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"(a) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.

"(b) Any mental disorder which requires medical services or results in physical or mental disability or death.

"(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death.

"(2) The worker must prove that employment conditions were the major contributing cause of the disease or its worsening. * * *

"(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:

"(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

"(b) Unless the employment conditions producing the mental disorder are conditions other than the conditions generally inherent in every working situation or reasonable disciplinary, corrective, or job performance evaluation actions by the employer, or cessation of employment.

"(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

We agree with the majority below that 1990 amendments to ORS 656.802 do not affect the analysis of the question before us; the introductory phrase and the wording of paragraph (1)(b) remain the same.

> "a heart attack, *whether it is caused by physical exertion, by on-the-job stress, or by both,* is an accidental injury within the meaning of ORS 656.005(7). A heart attack is not a 'mental disorder' within the meaning of ORS 656.802. Accordingly, the requirements relating to mental disorders established in ORS 656.802(3) do not apply to a claim for compensation for a heart attack." *Id.* at 242-243 (emphasis added; footnote omitted).

Thus, in reviewing the record of a workers' compensation claim, the Board's first task is to determine which provisions of the Workers' Compensation Law are applicable. In this case, if claimant's claim was based on her episode of colitis, whether caused by physical factors, by job stress, or by both, ORS 656.005(7) applies, because that episode is an **<319 Or 248/249>** "event" constituting an accidental injury. If, on the other hand, her claim was based on her personality disorder, ORS 656.802 (relating to occupational diseases in the form of mental disorders) applies, and the requirements of that provision must be met, whether the cause of the mental disorder was physical, non-physical, or both. *See generally* Diagnostic and Statistical Manual of Mental Disorders (3d ed (revised) 1987) (classifying mental disorders and specifying possible causes, including physical causes such as head trauma and non-physical causes such as worry about life circumstances). Finally, if claimant's claim encompasses both her episode of colitis and her personality disorder, the Board must analyze each claim separately under the applicable provision.

Claimant sought compensation for both her colitis and her personality disorder.[6] She alleged that those disabilities were caused by the stress of the May 14, 1991, meeting at work. The Board found that claimant's preexisting personality disorder was "unaffected by the stress at work" and that "the primary cause or major contributing cause of claimant's personality disorder, which [was] diagnosed in August 1991, was claimant's relationship with her mother and her inability to resolve her feelings after her mother died." The Board concluded that "claimant's psychological condition was due, in major part, to factors other than work conditions" and that claimant failed to prove "that her psychological condition arose out of and in the course of her employment." Substantial evidence supports the Board's findings relating to claimant's mental disorder. Given those findings, the Board was entitled to hold that claimant's mental disorder was not compensable under ORS 656.802.

The Board erred, however, in not analyzing separately, under ORS 656.005(7), claimant's episode of colitis, alleged to have been caused by the stress of the May 14, 1991, meeting at work. Claimant is entitled to the Board's review of that portion of her claim under the standards that apply to injuries.

319 Or 250> The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for further proceedings.

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[6] For the purpose of our review in this case, the parties agree that claimant's personality disorder is a "mental disorder" within the meaning of ORS 656.802. We assume that their characterization is correct, and we need not define "mental disorder" definitively to resolve the issue presented. *See Mathel v. Josephine County,* 319 Or 235, 242 n 2 ___ P2d ___ (1994) (explaining that court used that term in its ordinary sense).

Cite as 319 Or 319 (1994) July 21, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON

MARVIN **MOUSTACHETTI**, Respondent on Review,
v.
STATE OF OREGON, FAIRVIEW TRAINING CENTER, GEORGE GRAY, and JOHN DOES 1-10,
Petitioners on Review.
(CC 90C10101; CA A69332; SC S40901)

On review from the Court of Appeals.*

Argued and submitted May 10, 1994.

Harrison Latto, Assistant Attorney General, Salem, argued the cause for petitioners on review. With him on the petition were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Mark K. Grider, Salem, argued the cause and filed the response for respondent on review.

Richard C. Busse and Scott N. Hunt, Portland, filed a brief amicus curiae on behalf of the Oregon Trial Lawyers Association.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Unis, and Graber, Justices.

VAN HOOMISSEN, J.

The decision of the Court of Appeals is affirmed on different grounds. The judgment of the circuit court is reversed. The case is remanded to the circuit court for further proceedings.

*Appeal from Marion County Circuit Court, Rodney W. Miller, Judge. 122 Or App 598, 858 P2d 487 (1993).

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319 Or 321> This is an action for damages for wrongful discharge. The issue is whether defendants are immune from liability under ORS 30.265(3)(a).[1] The trial court granted summary judgment to defendants. The Court of Appeals reversed. *Moustachetti v. State of Oregon*, 122 Or App 598, 858 P2d 487 (1993). For the reasons that follow, we affirm the decision of the Court of Appeals on different grounds.

The trial court granted summary judgment to defendants.[2] The moving party has the burden of showing that there are no genuine issues of material fact and that he or she is entitled to judgment as a matter of law. ORCP 47 C. The record on summary judgment is viewed in the light most favorable to the party opposing the motion. *Seeborg v. General Motors Corporation*, 284 Or 695, 699, 588 P2d 1100 (1978). We therefore state the facts in the light most favorable to plaintiff.

Plaintiff was employed as a psychiatric security aide at the Fairview Training Center. In August 1985, he witnessed a supervisor abusing a resident. Plaintiff was questioned by the police about the incident and later was summoned to testify before a grand jury. Plaintiff was placed on administrative leave in November 1985. During the seven weeks he was on leave, he suffered headaches and sleeping problems, and he saw a psychiatrist.

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[1] ORS 30.265 provides in part:

"(3) Every public body and its officers, employees and agents acting within the scope of their employment or duties * * * are immune from liability for:

"(a)Any claim for injury to or death of any person covered by any workers' compensation law."

[2] Plaintiff named the state as a defendant, and he also named individuals acting as agents and employees of the state as defendants. He alleged that the acts of the agents were authorized, ratified, or undertaken within the scope of authority conveyed to them by the state or, alternatively, were independent acts of the individual defendants.

For purposes of this opinion, we will assume that all defendants are to be treated in the same manner as defendant state, because the parties do not argue otherwise and plaintiff has not asserted that the trial court erred in granting summary judgment on the ground that there were genuine issues of material fact as to whether the individual defendants were acting independently.

In 1987, a civil action was brought against the state on behalf of the resident who had been abused. In the course <319 Or 321/322> of defending that civil action, employees of the Department of Justice interviewed plaintiff. On September 1, 1987, plaintiff was placed on administrative leave pending an "abuse investigation."

In October 1987, SAIF Corporation received a workers' compensation claim from plaintiff stating that he was suffering from work-related "stress." An attached narrative explained that, after witnessing the abuse of the resident in August 1985 and later testifying before a grand jury, plaintiff developed stomach and sleeping problems and headaches. Plaintiff asserted that, when he was suspended in November 1985, his physical problems became worse and he consulted a psychiatrist; that he was reinstated in January 1986; that, in the spring of 1987, when Department of Justice employees interviewed him about the pending civil action, he suffered more stress; that he was physically injured on the job in June 1987; that in August 1987 he spoke again with Department of Justice employees about the civil action in August 1987; and that, when he was released by his doctor to return to work on September 1, 1987, he was told that he was being placed on administrative leave pending an "abuse investigation." Plaintiff continued to have sleeping and eating problems and sought counseling. SAIF accepted plaintiff's claim in January 1988 as a non-disabling compensable injury, and identifying August 1, 1985, as the date of injury.

On January 12, 1988, Fairview Training Center terminated plaintiff's employment. In December 1988, plaintiff was reinstated as an employee with an award of back pay and benefits pursuant to a labor arbitrator's ruling.

In January 1990, plaintiff brought this civil action against defendants for wrongful discharge, asserting that the termination of his employment with Fairview Training Center was retaliatory.

Plaintiff's complaint alleged in part:

> "Defendant[s] * * * caused plaintiff's termination in retaliation for the following:
>
> "1.[P]laintiff refused to cooperate with a cover-up of the physical beating of [a Fairview resident] on August 22, 1985, by a supervisor-employee of Fairview * * *;
>
> 319 Or 323> "2.[P]laintiff gave a witness statement describing the above-mentioned beating of [the resident] to members of the [Department of Justice] on or about August 21, 1987, in which plaintiff made it clear that his testimony as a witness in a pending lawsuit brought by the conservators of [the resident] against [the supervisor-employee] and the State of Oregon (Fairview) * * * would be extremely damaging in that it would support and corroborate the plaintiff's case against Fairview and its employees in that proceeding."

Plaintiff further alleged that defendants' conduct described above was intentional and caused him to suffer severe emotional distress, entitling him to non-economic damages.

Defendants' answer denied plaintiff's allegations and raised the affirmative defense of sovereign immunity, ORS 30.265(3)(a). Defendants moved for summary judgment. Their motion set forth the facts relating to plaintiff's workers' compensation claim. Defendants asserted that plaintiff's injury, compensated under the Workers' Compensation Law, was the same as the injury that he alleged in this action for wrongful discharge. Therefore, defendants argued, because they are immune from plaintiff's claim under ORS 30.265(3), they were entitled to summary judgment.

Plaintiff filed a legal memorandum, but did not file any affidavits or other evidentiary material in response to defendants' motion for summary judgment. Plaintiff argued that defendants were not immune under ORS 30.265(3)(a), because ORS 656.156(2) of the Workers' Compensation Law provides:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker * * * may take under this chapter, and also have cause for action against the employer, as if such

statutes had not been passed, for damages over the amount payable under those statutes."[3]

319 Or 324> The trial court concluded that, under ORS 30.265, defendants were immune from plaintiff's claim for wrongful discharge. Accordingly, the trial court entered summary judgment for defendants. Plaintiff appealed.

On appeal, the Court of Appeals, *in banc*, stated the question to be whether ORS 30.265(3)(a) grants immunity to a public body and its agents for liability resulting from its *intentional* injury of a worker who is subject to a Workers' Compensation Law. The court construed ORS 30.265(3)(a) and 656.156(2) together and held that in cases such as this the legislature intended that a trial court should treat plaintiff's claim as if no Workers' Compensation Law had been passed. The Court of Appeals stated:

> "We construe ORS 30.265(3)(a) and ORS 656.15 together to give effect to each. *Davis v. Wasco IED*, [286 Or 261, 272, 593 P2d 1152 (1979)]. Plaintiff's intentional tort claim is not 'covered' by the workers' compensation law, within the meaning of ORS 30.265(3)(a), because ORS 656.156(2) preserves his common law tort remedies and compels us to assume that the legislature did not enact a workers' compensation law regarding that claim. We do not ascribe to the legislature an intention to immunize the state or its agents from liability for intentional torts committed within the scope of employment." *Moustachetti v. State of Oregon, supra*, 122 Or App at 602-03 (footnote omitted).

The Court of Appeals therefore reversed the trial court and remanded the case. *Id.* at at 601-03. We allowed defendants' petition for review.

Plaintiff's complaint for wrongful discharge alleged that defendants terminated him in retaliation for his providing information about the abuse of the Fairview resident and for his refusing to cooperate with an alleged cover-up of that abuse. Plaintiff also alleged that he suffered "severe emotional distress," not as a separate tort claim, but in support of his claim for non-economic damages.

319 Or 325> The elements of a wrongful discharge claim are simple: there must be a discharge, and that discharge must be "wrongful." *See Nees v. Hocks*, 272 Or 210, 218, 536 P2d 512 (1975) (there can be circumstances in which an employer discharges an employee for such a socially undesirable motive that the employer must respond in damages for any injury done). There is no requirement that a plaintiff alleging wrongful discharge must also plead that he or she suffered "severe emotional distress." Defendants built their legal arguments in support of summary judgment around the notion that they were immune, because plaintiff's claim is for an injury "covered by worker's compensation law." ORS 30.265(3)(a). That premise, however, is erroneous. The legal "injury" alleged in an action for wrongful discharge is *the discharge*, not the type or severity of the damages suffered as a result of the discharge. Under the Workers' Compensation Law, on the other hand:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death * * *[.]" ORS 656.005(7)(a).

Plaintiff's discharge was a different "injury" than his "compensable injury" under the Workers' Compensation Law "requiring medical services or resulting in disability" that was accepted by SAIF in January 1988 and compensated under the Workers' Compensation Law.

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[3] Plaintiff argued to the trial court:

> "There is nothing in [defendant's summary judgment motion or exhibits] that indicates that in any way, shape or form Mr. Moustachetti's claim in the workers' compensation proceeding was for an intentional act in retaliation for his cooperation or perceived cooperation against some plaintiffs [*sic*] in a pending lawsuit against the State of Oregon for client abuse at Fairview. * * * This present lawsuit[, which does allege such circumstances,] is a different set of facts."

Plaintiff also argued that his complaint was based on the "deliberate intention exception" to the immunity described in ORS 656.156 "It's our contention that the State enjoys no broader immunity for its acts than any other employer in the State of Oregon with regard to the question of deliberate acts versus negligent acts."

ORS 30.265(3)(a) provides immunity to the state from liability for "[a]ny claim for injury to or death of any person covered by any workers' compensation law." In interpreting a statute, the court's task is to determine the intent of the legislature. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, 859 P2d 1143 (1993) (so stating). The starting points in that determination are the text and context of the statute. *Ibid.* Words of common usage typically should be given their plain, natural, and ordinary meanings. *Ibid.*

Defendants argue that, in this case, ORS 30.265(3)(a) should be construed as immunizing them from liability because plaintiff's claim is brought by a "person covered by any workers' compensation law." Defendants argue that the focus of the statute is on "person" and that the statute should be interpreted as providing immunity for any claim of *any* **<319 Or 325/326>** person "covered by any workers' compensation law." That interpretation is not tenable, however, because it renders meaningless the phrase "for injury to or death of" in the statute. *See* ORS 174.010 (in statutory interpretation, the court is not to omit what has been inserted, and when possible should adopt statutory construction that will give effect to all particulars of a statute).

Defendants counter that, if the focus is placed on whether the claim is "for injury to" or "death of" any person who is "covered by any workers' compensation law," then the phrase "of any person" in the statute becomes superfluous. We disagree. Although injury and death likely would be understood in this context to refer to *personal* injury and death, even if the legislature had not included the additional phrase "of any person" in the provision, that is not the only permissible reading of the statute in the absence of the phrase "of any person." The inclusion of the phrase "of any person" in the statute providing immunity for "any claim for injury to or death of any person covered by any workers' compensation law" helps to make clear that the immunity applies, whether or not a workers' compensation claim for death or injury actually was filed.[4]

ORS 30.265(3)(a) establishes that every public body (and its officers, employees, and agents acting within the scope of their employment or duties) is immune from liability in a civil action (1) when the civil action states a claim for injury to or death of any person, and (2) when the injury to or death of that person occurred while that person and that injury were covered by (or under) any Workers' Compensation Law. The context of the statute does not alter what its text demonstrates and, therefore, we need not go beyond the first level of analysis to decide this case. *See PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611 (explaining the methodology).

319 Or 327> Plaintiff filed his workers' compensation claim in October 1987, alleging work-related "stress" beginning in August 1985 and continuing through September 1987. He was not terminated, *i.e.*, "injured" for purposes of his wrongful discharge claim, until January 1988. Although plaintiff has alleged underlying facts (such as the abuse of the resident and the subsequent cover-up) that are pertinent both to his workers' compensation claim and to his wrongful discharge claim, that does not necessarily lead to a conclusion that his wrongful discharge claim is a "claim for injury to or death of any person covered by any workers' compensation law." Because plaintiff's workers' compensation claim and his wrongful discharge claim do not allege the same injury, defendants are not immune under ORS 30.265(3)(a).

We conclude that plaintiff's wrongful discharge claim does not fall within the scope of the immunity provided by ORS 30.265(3)(a), because it is not a "claim for injury to or death of any person covered by any workers' compensation law." Defendants were not entitled to summary judgment based on the immunity provisions of ORS 30.265(3)(a).

The decision of the Court of Appeals is affirmed on different grounds. The judgment of the circuit court is reversed. The case is remanded to the circuit court for further proceedings.

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[4] Moreover, from the text of ORS 30.265(3)(a), we believe that it was more likely that the legislature was focused on the nature of the claim rather than on the identity of the claimant, because the legislature could assume that most people work and that every worker should be a "person" covered by workers' compensation laws. That being so, if the statute means what the state argues that it means, almost every person would be denied a civil cause of action on a claim for wrongful discharge, because most workers are covered by workers' compensation laws.

Cite as 319 Or 417 (1994) August 4, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON

GARY **NEHER**, Personal Representative of the Estate of Julie Neher, deceased, Petitioner on Review.
v.
LARRY LEE **CHARTIER**, and TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON, a municipal corporation, doing business under the assumed business name of Tri-Met, Respondents on Review.
(CC A9112-08001; CA A75617; SC S40950)

In Banc

On review from the Court of Appeals.*

Argued and submitted May 10, 1994.

Elden M. Rosenthal, of Rosenthal & Greene, P.C., Portland, argued the cause for petitioner on review. With him on the brief was B. Carlton Grew, Portland.

John R. Faust, Jr., of Schwabe Williamson & Wyatt, Portland, argued the cause and filed the response for respondents on review.

David F. Sugerman, of Paul & Sugerman, Portland, filed a brief amicus curiae on behalf of the Oregon Trial Lawyers Association.

Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and Robert M. Atkinson, Assistant Attorney General, Salem, filed a brief amicus curiae on behalf of the State of Oregon.

VAN HOOMISSEN, J.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed. The case is remanded to the circuit court for further proceedings.

*Appeal from Multnomah County Circuit Court, Robert W. Redding, Judge. 124 Or App 220, 862 P2d 1307 (1993).

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319 Or 420> ORS 30.265(3)(a), a part of the Oregon Tort Claims Act (OTCA), provides that public bodies and their officers, employees, and agents, acting within the scope of their employment, are immune from liability for claims for injury to or death of any person covered by any workers' compensation law. At issue in this case is whether ORS 30.265(3)(a) violates Article I, section 10,[1] or Article I, section 20,[2] of the Oregon Constitution. The Court of Appeals held that the statute violated neither provision of the Oregon Constitution. *Neher v. Chartier*, 124 Or App 220, 862 P2d 1307 (1993). For the reasons that follow, we conclude that the tort immunity provided by ORS 30.265(3)(a) violates Article I, section 10, of the Oregon Constitution, because it purports to immunize public bodies from tort liability as well as the public body's officers, employees, and agents of public bodies. Accordingly, we reverse the decision of the Court of Appeals.

The facts of this case are not complicated. Plaintiff's adult daughter, Neher, was struck and killed by a Tri-Met bus while she was crossing the street in a marked crosswalk and while a "walk" signal was on in the direction in which she was walking.[3] The bus was driven by defendant Chartier, an employee of defendant Tri-County Metropolitan Transportation District of Oregon (Tri-Met), who was acting within the scope of his employment.

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[1] Article I, section 10, of the Oregon Constitution, provides:

"No court shall be secret, but justice shall be administered, openly and without purchase, completely and without delay, and every man shall have remedy by due course of law for injury done him in his person, property, or reputation."

[2] Article I, section 20, of the Oregon Constitution, provides:

"No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

[3] At the time of the accident, Neher was engaged in an activity that was covered under the Workers' Compensation Law. ORS ch 656.

Defendants alleged in an affirmative defense in their reply brief that, at the time of her death, Neher was covered by the Oregon Workers' Compensation Law. Plaintiff's reply admitted that Neher was covered by the Oregon Workers' Compensation Law.

Plaintiff, as personal representative of his estate, brought this wrongful death action against Chartier and <319 Or 420/421> Tri-Met. *See* ORS 30.010 *et seq.* (describing actions for wrongful death).[4] Defendants moved for judgment on the pleadings, ORCP 21 B,[5] arguing that they were immune from liability under ORS 30.265(3)(a).[6] Plaintiff responded that, if ORS 30.265(3)(a) were construed as barring plaintiff from recovery for his daughter's wrongful death, then the statute would violate Article I, sections 10 and 20, of the Oregon Constitution.[7] The trial court granted defendants' motion and entered judgment in their favor.

On appeal, the Court of Appeals rejected plaintiff's challenge under Article I, section 10, noting that workers' compensation death benefits of up to $3,000 for burial expenses were available to the estate, ORS 656.204(1), and concluding that "we cannot say that the substitution of that remedy under the workers' compensation system for any remedies [plaintiff] would otherwise have had against Tri-Met or its driver, is a complete denial of a substantial remedy." *Neher v. Chartier, supra,* 124 Or App at 224.

The Court of Appeals also rejected plaintiff's challenge under Article I, section 20, on the ground that the prohibition against providing special treatment to favored individuals or classes of citizens applies only to a "true class" while the classifications on which plaintiff relied as a basis for <319 Or 421/422> the argument under Article I, section 20, were created by statute and not based on "antecedent personal or social characteristics or societal status." *Id.* at 227-28 (quoting *Hale v. Port of Portland,* 308 Or 508, 525, 783 P2d 506 (1989)). The Court of Appeals thus concluded that the trial court correctly had dismissed plaintiff's claim. *Id.* at 228.

On review, plaintiff argues that the $3,000 burial payment remedy provided under ORS 656.204(1) of the Workers' Compensation Law, if it is to be the exclusive remedy for the wrongful death of the decedent at the hands of a public employee, is a denial of a "substantial" remedy, in violation of Article I, section 10, of the Oregon Constitution. Plaintiff also contends that ORS 30.265(3)(a) violates Article I, section 20, of the Oregon Constitution, by granting tort immunity to the class comprised of public employees and by denying recovery to the parents of nondependent children covered by workers' compensation laws for their children's deaths, but while permitting recovery to parents of other children.

Defendants respond that Article I, section 10, is not violated because plaintiff is not left without a remedy, and because Article I, section 10, applies only to protect claims that were available under common law. Defendants also argue that plaintiff's rights under Article I, section 20, were not violated because, even if the Court of Appeals was incorrect in determining that the classes in question were created by statute, there was no invidious or otherwise constitutionally impermissible discrimination in differentiating between public employees and others.

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[4] ORS 30.020 provides in part:

"(1) When the death of a person is caused by the wrongful act or omission of another, the personal representative of the decedent, for the benefit of the decedent's surviving spouse, surviving children, surviving parents and other individuals, if any, who under the law of intestate succession of the state of the decedent's domicile would be entitled to inherit the personal property of the decedent, and for the benefit of any stepchild or stepparent whether that stepchild or stepparent would be entitled to inherit the personal property of the decedent or not, may maintain an action against the wrongdoer, if the decedent might have maintained an action, had the decedent lived, against the wrongdoer for an injury done by the same act or omission."

[5] ORCP 21 B provides:

"After the pleadings are closed, but within such time as not to delay the trial, any party may move for judgment on the pleadings."

[6] ORS 30.265(3) provides in part:

"Every public body and its officers, employees and agents acting within the scope of their employment or duties, * * * are immune from liability for:

"(a) Any claim for injury to or death of any person covered by any workers' compensation law."

[7] Plaintiff makes no statutory or federal constitutional argument.

There are three levels on which the interpretation of a provision of the Oregon Constitution must be addressed: "Its specific wording, the case law surrounding it, and the historical circumstances that led to its creation." *Priest v. Pearce*, 314 Or 411, 415-16, 840 P2d 65 (1992).

Article I, section 10, of the Oregon Constitution, provides in part that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation." That "remedies" clause has no counterpart in the federal constitution, and the scope of its constitutional guarantees is less than clear from the words of the text, **<319 Or 422/423>** leaving room for interpretation. *See, e.g.*, Schuman, *The Right to a Remedy*, 65 Temple L Rev 1197 (1992) (discussing interpretations of various remedies clauses in state constitutions and listing several possible ways to interpret Article I, section 10, in particular); Linde, *Without "Due Process,"* 49 Or L Rev 125 (1970) (discussing possible constitutional interpretations of Article I, section 10, in terms of whether its "due course of law" provision serves as a guarantee of procedural due process). This court's case law throughout the nineteenth and twentieth centuries interpreting Article I, section 10, likewise has failed definitively to establish and consistently to apply any one theory regarding the protections afforded by the remedies guarantee. *See* Schuman, *Oregon's Remedy Guarantee: Article I, Section 10 of the Oregon Constitution*, 65 Or L Rev 35, 40-41 (1986) (so noting).

This court summarized the application of the remedies guarantee to various governmental tort immunities in *Hale v. Port of Portland, supra*, 308 Or at 520-21, a case involving constitutional challenges to the damages limitation provisions of the OTCA:

> "Through a convoluted series of decisions by this court, the rule evolved that these charter provisions [absolving cities of liability in tort cases] did not violate Article I, section 10, so long as they did not wholly eliminate the injured party's remedies. For example, charter provisions absolving both the municipality and its officers from liability were invalidated, while those that did not eliminate the injured party's right to recover from the municipal corporation's officers were upheld.[9]" 308 Or at 519-20.

> "[9] *Compare, e.g., Mattson v. Astoria*, 39 Or 577, 65 P 1066 (1901) (charter provision invalid where it immunized both the city and its officers, thereby denying plaintiff any remedy); *Noonan v. City of Portland*, [161 Or 213, 248, 88 P2d 808 (1939)] (charter provision satisfied Article I, section 10, where it did not purport to immunize the city's officers from liability)."

In *Hale*, 308 Or at 521, this court quoted with approval from *Noonan v. City of Portland*, 161 Or 213, 249-50, 88 P2d 808 (1939):

> "'Article I, 10, Oregon Constitution, was not intended to give anyone a vested right in the law either statutory or **<319 Or 423/424>** common; nor was it intended to render the law static. Notwithstanding similar constitutional provisions in other states, the courts have sustained statutes which eliminated the husband's common law liability for the torts of his wife and which placed the wife upon an economic level with her husband. They have likewise sustained statutes which have abolished actions for alienation of affections, actions for breach of promise, etc. The legislature cannot, however, abolish a remedy and at the same time recognize the existence of a right[.]'" (Citations omitted.)

The *Hale* court went on to note that that passage in Noonan was consistent with the court's decision in *Evanhoff v. State Industrial Acc. Com.*, 78 Or 503, 154 P 106 (1915), which upheld the newly enacted workers' compensation system against an Article I, section 10, challenge. *Hale v. Port of Portland, supra*, 308 Or at 521. The *Hale* court concluded :

> "*Noonan* and *Evanhoff* held only that Article I, section 10, is not violated when the legislature alters (or even abolishes) a cause of action, so long as the party injured is not left entirely without a remedy. Under those cases, the remedy need not be precisely of the same type or extent; it is enough that the remedy is a substantial one." *Id.* at 523 (citing *Noonan v. City of Portland, supra; Evanhoff v. State Industrial Acc. Com., supra; Perozzi v. Ganiere*, 149 Or 330, 40 P2d 1009 (1935); *Davidson v. Rogers*, 281 Or 219, 574 P2d 624 (1978)).

In a concurring opinion in *Hale*, Justice Linde noted, in regard to the Article I, section 10, question:

> "[T]he court has allowed legislative immunization of cities from tort liability only on condition that the individuals who are personally responsible for harm qualifying as a legal injury remain liable. *Batdorff v. Oregon City*, 53 Or 402, 100 P 937 (1909); *Mattson v. Astoria*, 39 Or 577, 65 P 1066 (1901). This is analogous to altering or limiting the scope of *respondeat superior* rather than wholly depriving a plaintiff of a remedy in due course of law *for harm that no one has declared not to be a legal injury* when caused by public rather than private negligence. Because this case presents no claim against individual public 'officers or employees, or agents,' ORS 30.265, I concur with the court." *Id.* at 530. (Emphasis added.)

The present action, in essence, presents the question raised in Justice Linde's concurrence.

319 Or 425> *Mattson v. Astoria, supra*, 39 Or at 578, involved a tort claim for an injury alleged to have been caused by the city's failure to repair a street. The city charter provided that "neither the City of Astoria nor any member of the council thereof shall in any manner be held liable for any damages resulting from a defective condition of any street, alley, or highway thereof." *Ibid.* This court held that the quoted provision violated Article I, section 10, of the Oregon Constitution:

> "That it is within the power of a legislature to exempt a city from liability to persons receiving injuries on account of streets being defective or out of repair, is unquestioned[.] * * * But in such case the injured party is not wholly without remedy. He may proceed personally against the officers to whom the charter delegates the duty of keeping the streets in repair, and from whose negligence the injury resulted." *Id.* at 579.

The court added:

> "[Article I, section 10,] was intended to preserve the common-law right of action for injury to person or property, and while the legislature may change the remedy or the form of procedure, attach conditions precedent to its exercise, and perhaps abolish old and substitute new remedies * * *, it can not deny a remedy entirely." *Id.* at 580.

Thus, in *Mattson*, the reason why immunity could not be extended to the officers as well as to the city was that it would have left the plaintiff "wholly without remedy," in violation of the remedies guarantee of Article I, section 10, of the Oregon Constitution.

Similarly, in *Batdorff v. Oregon City, supra*, 53 Or at 403-04, the plaintiff brought an action against the city and individual members of its council for an injury caused by failure to repair a sidewalk. The city's charter provided that the city would not be liable for injury arising out of conditions of streets or public grounds, but that that provision did "not exonerate any officer of Oregon City or any other person from such liability, when such casualty or accident is caused by the willful neglect of any duty enjoined upon such officer or person by law, or by the gross negligence or willful misconduct of such officer or person in any other respect." *Id.* at 404. **<319 Or 425/426>** Again, this court struck down the provision under Article I, section 10:

> "If this clause be upheld as a valid exercise of the legislative will, it necessarily follows that a person will be remediless who sustains a pecuniary loss in consequence of an improved street being in a defective condition which was occasioned by ordinary negligence." *Id.* at 408-09.

The court's reasoning for striking down the charter provision under the remedies guarantee of Article I, section 10, was to avoid leaving certain plaintiffs without remedy.

We do not interpret those cases to stand for the proposition that legislation extending tort immunity to public officers and employees is constitutionally infirm *per se* under Article I, section 10. Rather, they stand for the proposition that such legislation violates Article I, section 10, if the effect of the immunity provisions is to render tort plaintiffs "without remedy," *Mattson v. Astoria, supra*, 39 Or at

579, or "remediless," *Batdorff v. Oregon City, supra,* 53 Or at 408. That is consistent with the conclusion in *Hale v. Port of Portland, supra,* 308 Or at 523, that Article I, section 10, is not violated "so long as the party injured is not left entirely without a remedy," and "that the remedy is a substantial one."

Plaintiff concedes that Neher's *estate* is entitled, under the Workers' Compensation Law, ORS 656.204(1), to recover for "[t]he cost of burial, including transportation of the body, * * * not to exceed $3,000 in any case." Neher's estate as such, therefore, has not been left entirely without a remedy. The estate, however, is not the only real party in interest in the wrongful death action.

This action was brought by the personal representative of Neher's estate. Under the wrongful death statute, the personal representative of a decedent's estate does not bring a wrongful death action solely on behalf of the estate, but also "for the benefit of the decedent's * * * surviving parents." ORS 30.020(1). Damages under the wrongful death statute may be awarded that "[j]ustly, fairly and reasonably compensate the decedent's * * * parents for pecuniary loss and for loss of the society, companionship and services of the decedent." ORS 30.010(2)(d). Thus, although the decedent's <319 Or 426/427> estate (for which a parent happens to serve as personal representative) has not been left "wholly without remedy," the surviving parents of the decedent, who otherwise would be entitled to recover under ORS 30.010(2)(d), *have* been left wholly without a remedy.

Defendants contend that there is no violation of Article I, section 10, even if the real parties in interest have been left without a remedy, because Article I, section 10, protects only rights that existed at common law before the adoption of the Oregon Constitution.[8] Although it is true that some of this court's older case law suggested that distinction, this court rejected that line of reasoning in *Noonan v. City of Portland, supra,* 161 Or at 249:

> "Article I, 10, Oregon Constitution, was not intended to give anyone a vested right in the law either statutory or common; nor was it intended to render the law static. * * *. The legislature cannot, however, abolish a remedy and at the same time recognize the existence of a right[.]" (Citations omitted.)

As noted above, that language was quoted with approval in *Hale v. Port of Portland, supra,* 308 Or at 521. *See also* Schuman, *supra,* 65 Or L Rev at 44-49 (recognizing court's abandonment of line of cases that remedies clause froze the law as it existed in 1859).

In *Noonan v. City of Portland, supra,* unlike in *Batdorff* and *Mattson,* the limitation on a municipality's liability for negligently caused injuries did not violate Article I, section 10, because, although the limitation "withholds a remedy against the city, it recognizes a liability in the negligent officials and creates a right of action against the abutting property owner." *Noonan,* 161 Or at 248. Thus, while the existence of the right was recognized, the remedy was not abolished. In *Noonan,* this court recognized the legislature's ability to change the law, and in fact to abolish entirely a right of action,[9] whether or not the right involved had existed at <319 Or 427/428> common law at the time of the Oregon Constitutional Convention. In substance, the distinction between a statutory claim and a common law claim was abandoned for purposes of Article I, section 10, analysis. The legislature's ability to make such alterations to rights of action, however, was not unfettered: it could not "abolish a remedy and at the same time recognize the existence of a right." *Id.* at 249.

ORS 30.010 recognizes the existence of a right of recovery for surviving parents for damages to compensate them "for pecuniary loss and for loss of the society, companionship and services of the decedent." ORS 30.010(2)(d). ORS 30.265(3)(a), however, operates to abolish the parents' remedy under circumstances such as those present in this case, not only against the municipality, but against the

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[8] This court has stated that "there is no common law cause of action for wrongful death." *Goheen v. General Motors Corp.,* 263 Or 145, 151, 502 P2d 223 (1972) (citing cases).

[9] *See, e.g., Noonan v. City of Portland,* 161 Or 213, 249, 88 P2d 808 (1930) (citing with approval statutes that have abolished common law rights); *Perozzi v. Ganiere,* 149 Or 330, 245-48, 40 P2d 1009 (1935) (upholding guest passenger statute).

municipality's negligent employees. Such a result is irreconcilable with this court's holdings in Mattson v. Astoria, supra; *Batdorff v. Oregon City, supra;* and *Noonan v. City of Portland, supra. See also Hale v. Port of Portland, supra,* 308 Or at 530 (Linde, J., concurring) (citing *Mattson* and *Batdorff,* and pinpointing potential OTCA problem).[10]

We conclude that ORS 30.265(3)(a), which provides that public bodies and their officers, employees, and agents, acting within the scope of their employment are immune from liability for claims for injury to or death of any person covered by any workers' compensation law, violates Article I, section 10, of the Oregon Constitution, because it has left plaintiff without a remedy.

Because we hold that plaintiff's wrongful death action was entitled to proceed on the basis of his arguments under Article I, section 10, we need not address his alternative arguments under Article 1, section 20.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed. The case is remanded to the circuit court for further proceedings.

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[10] Although interpretation of constitutional provisions generally entails an examination not only of the text and the case law, but also of the historical circumstances, *see Priest v. Pearce,* 314 Or 411, 415-16, 840 P2d 65 (1992), the parties have not brought to the court's attention any historical circumstances that shed light on the meaning of Article I, section 10, of the Oregon Constitution, and the court is aware of none.

Cite as 127 Or App 333 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lisa D. Henderson, Claimant.

LISA D. **HENDERSON**, Petitioner,
v.
S.D. DEACON CORPORATION and SAIF CORPORATION, Respondents.
(92-03276; CA A79202)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 20, 1993.
John Mayfield argued the cause and filed the brief for petitioner.
Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.
DEITS, P.J.
Reversed and remanded.
*Haselton, J., *vice* Durham, J.

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127 Or App 335> Claimant seeks review of a Workers' Compensation Board order holding that her injury was not compensable. The issue is whether the relationship between claimant's injury and her employment is sufficient to conclude that the injury was work-connected and, therefore, compensable. We reverse.

The facts are not disputed. Claimant worked on the fourth floor of an office building that is leased by employer. There are no lunch facilities on the fourth floor. Employer required claimant to take a one hour unpaid lunch break, and her supervisor encouraged her to leave the building during that time. When her lunch hour arrived, claimant rode the elevator to the first floor. She was injured when she attempted to step out of the elevator, because the elevator had stopped above the level of the first floor.

Claimant argues that the Board erred in concluding that her injury was not sufficiently related to her work to be compensable. An injury is compensable if it "aris[es] out of and in the course of employment." ORS 656.005(7)(a). "'[A]rising out of' and 'in the course of' are two elements of a single inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable." *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 867 P2d 1373 (1994). Each of these elements tests the work connection of an injury in a different way. Both factors must be evaluated in determining work connection; neither is dispositive. As the Supreme Court explained in *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983), there is not an absolute minimum that must be met for each element of the work-connection test. Deficiencies in the strength of one factor may be made up by the strength of the other. In *Livesley*, the court quoted Professor Larson:

> "One is almost tempted to formulate a sort of quantum theory of work-connection that a certain minimum quantum of work-connection must be shown, and if the 'course' quantity is very small, but the 'arising' quantity is large, the quantum will add up to the necessary minimum, as it will also when the 'arising' quantity is very small but the 'course' quantity is relatively large.
>
> **127 Or App 336>** "But if both the 'course' and 'arising' quantities are small, the minimum quantum will not be met." 1A Larson, *Workmen's Compensation Law* 5-476, 29.10 (1993). (Footnote omitted.)

The requirement that the injury occur "in the course of employment" concerns the time, place and circumstances of the injury. *Norpac Foods, Inc. v. Gilmore, supra*, 318 Or at 366. As discussed above, claimant's injuries occurred just as she was leaving her work place for lunch. The Oregon courts follow the "going and coming rule," which provides that injuries sustained while going to or coming from the workplace are not compensable. *Cope v. West American Ins. Co.*, 309 Or 232, 237, 785 P2d 1050 (1990).

There are, however, exceptions to the going and coming rule. One exception is referred to as the "parking lot rule." Under that exception, when an employee traveling to or from work sustains an injury "on or near" the employer's premises, the "in the course of" portion of the work-connection test may be satisfied if "the employer exercises some 'control' over the place where the injury is sustained." *Cope v. West American Ins. Co., supra,* 309 Or at 239. As the Supreme Court explained:

> "[W]hen an employee traveling to or from work sustains an injury on or near the employer's premises, there is a 'sufficient work relationship' between the injury and the employment only if the employer exercises some 'control' over the place where the injury is sustained. Whether the requisite control is evinced by increased, employer-created risks, or by the employer's property rights to the area where the injury is sustained, is immaterial. Some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable." (Citations omitted.)

The Board concluded that claimant did not satisfy the control element of the "in the course of" part of the work-connection-test:

> "Thus, the employer did not own the building, was not responsible for maintaining the elevator, and could not require the landlord to repair the elevator. Actual control by the employer of the area of injury is necessary to establish control. * * * Accordingly, under the 'going and coming' rule, we find that claimant was not within the course and scope of her employment when her injury occurred."

127 Or App 337> We do not agree with the Board's conclusion that employer did not have sufficient control of the elevator to satisfy the "in the course of" element of the work-connection test. Ownership, or even a leasehold interest in the place where the injury occurred, is not always required. *Montgomery Ward v. Malinen,* 71 Or App 457, 692 P2d 694 (1984); *Montgomery Ward v. Cutter,* 64 Or App 759, 669 P2d 1181 (1983). As explained by Larson:

> "When the place of employment is a building, it is not necessary that the employer own or lease the place where the injury occurred. It is sufficient if he has some kind of right of passage, as in the case of common stairs, elevators * * * or passage ways through which the employer has something equivalent to an easement." 1 Larson, *Workmen's Compensation Law* 4-132, 15.43 (1990). (Footnotes omitted.)

See Philpott v. State Ind. Acc. Com., 234 Or 37, 41, 379 P2d 1010 (1963).

Claimant contends that the Board's finding that the employer could not require the landlord of the building to maintain and repair the elevator is not supported by substantial evidence. We agree. Employer's lease gave it a nonexclusive right to use the elevator, and provided that the landlord "shall have no obligation to make repairs * * * *until* a reasonable time after receipt of written notice from [employer] of the need for such repairs." (Emphasis supplied.) Under the terms of the lease, once the landlord had received written notice from employer, and after a reasonable amount of time had passed, the landlord was required to make the requested repairs. The fact that, as a practical matter, it might be difficult to get the landlord to repair the elevator, did not eliminate employer's right to require repairs. The lease also provided for employer to pay its share of "operating expenses," including "normal maintenance and repairs of the building and Common Areas," after one year of employer's occupancy. We conclude that under the particular circumstances here, there was a sufficient connection between the employer and the area where the injury occurred to satisfy the "in the course of" element of the work-connection test.

Our next inquiry is whether the "arising out of" element of the work-connected test is satisfied here. This element measures the causal connection between the injury **<127 Or App 337/338>** and the employment. *Norpac Foods, Inc. v. Gilmore, supra,* 318 Or at 366. The Board concluded that there was not a sufficient causal connection between claimant's injury and her work. However, in reaching that conclusion, the Board relied strongly on our decision in *PP&L v. Jacobson,* 117 Or App 280, 844 P2d 223 (1992). In that case, we held that there was not a sufficient work connection because the claimant's injury occurred during his lunch hour and was not an anticipated risk of his employment. However, on reconsideration of our decision in Jacobson, which occurred after the Board's decision here, we

withdrew the earlier opinion and held that there was substantial evidence to support the Board's finding that claimant's injury was an anticipated risk of employment. *PP&L v. Jacobson*, 121 Or App 260, 854 P2d 999, *rev den* 317 Or 583 (1993). Accordingly, the *Jacobson* decision no longer supports the Board's conclusion that there was no causal connection here between claimant's work and her injury. The reconsidered *Jacobson* decision is pertinent in that it emphasizes that one focus in determining if an injury "arose out of" an employee's work is whether what occurred was an anticipated risk of employment. Otherwise, however, the decision is not controlling here because, in that case, the employee's work required him to travel throughout his work day and on a daily basis.

In assessing whether there is a sufficient causal link between a claimant's injury and employment, the connection between the claimant's work and what happened must be evaluated. Part of that inquiry is whether what occurred was an anticipated risk of employment. As explained by Larson:

> "All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and 'neutral' risks--*i.e.*, risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance." 1 Larson, *supra*, at 3-12.

We conclude, based on the facts found by the Board, that claimant's injury arose out of her employment. **<127 Or App 338/339>** Employer's knowledge of claimant's repeated use of the elevator to arrive and leave her workplace, the lack of alternative means to arrive and leave the fourth floor coupled with the necessity that claimant do so, the unavailability of lunch facilities at the workplace, and employer's preference that claimant leave the building for lunch, show that claimant's conditions of employment put her in a position to be injured. Both elements of the work-connection-test are sufficiently satisfied here to support the holding that claimant's injury was work related. The Board erred in upholding the denial of claimant's injury.

Reversed and remanded.

Cite as 127 Or App 346 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Carole A. Vanlanen, Claimant.

SAIF CORPORATION and BELOZER FARMS, Petitioners,
v.
CAROLE A. **VANLANEN**, Respondent.
(WCB 91-13600; CA A76539)

Judicial Review from Workers' Compensation Board.
On respondent's petition for reconsideration filed June 23, 1993. Opinion filed June 2, 1993. 120 Or App 613, 852 P2d 281.
Alan M. Scott, Steven T. Fagenstrom and Galton, Scott & Colett for petition.
Before Deits, Presiding Judge, and Riggs, Judge, and Durham, Judge pro tempore.
DEITS, P.J.
Reconsideration allowed; opinion adhered to.
Durham, J. pro tempore, dissenting.

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127 Or App 348> Claimant requests reconsideration of our decision in this case, arguing that our reliance on *Diamond Fruit Growers v. Goss*, 120 Or App 390, 852 P2d 915, *rev den* 317 Or 583 (1993), was in error and that, in any event, our conclusion that payment of benefits awarded by a determination order was stayed under ORS 656.313 was wrong. We allow reconsideration and adhere to our former opinion.

In November, 1990, claimant filed a claim for a work-related back injury that was denied by SAIF. Claimant sought review of the denial, and the referee held that the claim was compensable. SAIF sought Board review of the referee's order. Under *Diamond Fruit Growers v. Goss, supra,* because SAIF's request for Board review of the compensability issue took place after July 1, 1990, the amended version of ORS 656.313 was applicable and SAIF was entitled to a stay of payment of compensation. While Board review was pending, claimant became medically stationary and her claim was closed. A determination order was issued awarding her TTD and PPD. SAIF did not appeal the determination order, but refused to pay benefits pending the Board's resolution of the compensability issue. Claimant sought Board review of SAIF's failure to pay. The Board agreed with claimant and ordered SAIF to pay her benefits. SAIF sought review of the Board's order, and we concluded that SAIF was entitled to a stay pending resolution of the compensability question.

In her petition for reconsideration, claimant argues that our earlier opinion erred in relying on *Diamond Fruit Growers v. Goss, supra,* because the question presented here was not decided in that case. She also contends that our conclusion in that case, that the stay resulting from SAIF's appeal of the compensability decision also stays payment of benefits awarded in a subsequent determination order, is wrong. She asserts that ORS 656.313, as amended, requires a separate appeal of the determination order in order for payment of benefits awarded there to be stayed, and that because SAIF did not appeal the determination order, it was required to pay those benefits.

Contrary to claimant's assertions, this question was presented in *Diamond Fruit Growers*. The necessity of **<127 Or App 348/349>** appealing a determination order in order to preserve a stay obtained under the amended version of ORS 656.313 was specifically considered both by the Board and by this court. As we explained in *Diamond Fruit Growers*, the Board initially took the position that it did in this case that, under amended ORS 656.313, it was necessary for an employer to separately appeal a determination order to obtain a stay of the compensation awarded in the determination order. However, the Board subsequently disavowed that holding. We explained in *Diamond Fruit Growers*:

> "After its decision in this case, the Board, sitting in banc, disavowed a portion of its holding here in *Felipe A. Rocha*, 45 Van Natta 47 (1993). It held in Rocha that, when an employer is entitled to a stay of compensation under ORS 656.313, it is not necessary for the employer to seek review of a determination or closure order issued during the pendency of the appeal in order to preserve the stay. However, *if the employer otherwise disagrees with the order, it would be necessary to appeal the determination order for those purposes.*" 120 Or App at 393. (Emphasis supplied.)

In *Diamond Fruit Growers*, we also said:

> "We agree with the Board's reasoning in *Rocha* concerning the necessity of appealing a determination order in order to preserve a stay under ORS 656.313. Accordingly, the fact that employer here did not appeal the determination order issued in September, 1990, does not preclude its entitlement to a stay under ORS 656.313, if it was otherwise entitled to one. Whether it was entitled to one becomes the critical question." 120 Or App at 394.

Claimant argues here that our conclusion is inconsistent with the Supreme Court's decision in *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988). That case, however, is not controlling here. It concerned the interpretation of the old version of ORS 656.313, which provided that payment of compensation was not stayed pending appeal. Employer there argued that the prohibition of stays pending appeal did not extend to appeals of determination orders and that, therefore, they should be allowed to stay payment of compensation awarded under a determination order. The court rejected that argument and held that the prohibition of stays pending appeals of compensability extended to appeals **<127 Or App 349/350>** of determination orders. That is not the same question presented here.

For all of the above reasons, we adhere to our previous disposition of this issue and conclude that SAIF was entitled to a stay of payment of compensation pending appeal.

Reconsideration allowed; opinion adhered to.

DURHAM, J. pro tempore, dissenting.

The Board held that payments under the August 15, 1991, determination order, which awarded TTD and PPD, are not stayed by SAIF's prior request for Board review of the referee's decision that the low back injury is compensable. In *SAIF v. Vanlanen*, 120 Or App 613, 614, 852 P2d 281 (1993), we reversed the Board and said:

> "We conclude that, under ORS 656.313, employer's May 23, 1991, appeal of the referee's order on compensability did stay payment of benefits awarded by the later determination order. *Diamond Fruit Growers v. Goss*, 120 Or App 390, 852 P2d 915, [*rev den* 317 Or 583] (1993)."

The majority allows reconsideration and adheres to that reasoning. I agree that we should reconsider our opinion, but I would affirm the Board.

Diamond Fruit Growers v. Goss, supra, is not authority for the majority's result, because it arose under the law in effect before the 1990 amendment to ORS 656.313. Or Laws 1990, ch 2, 23. *Diamond Fruit Growers* held, correctly, that "the Board did not err in holding that employer was not entitled to a stay because its request for review occurred before July 1, 1990." 120 Or App at 394. Because *Diamond Fruit Growers* was a pre-amendment case, the court's comments about the effects of the statutory amendment were *dicta*. This is our first post-amendment case to pose the question whether an employer that requests review of a referee's compensability ruling is entitled to refrain from paying compensation ordered in a subsequent, unappealed determination order.

I turn first to the text of the relevant statutes as they existed before 1990. ORS 656.262(2), which was not amended, provides:

> **127 Or App 351>** "The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except where the right to compensation is denied by the insurer or self-insured employer."

Before 1990, ORS 656.313(1) provided:

> "Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."

In *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988), the employer terminated disability payments awarded in a determination order, asserting that the claimed injury, which the employer had accepted, was not compensable. The employer argued that it was not required to make payments on a determination order before the issues of compensability and the extent of disability were determined by the Board. The court held that the employer's argument was "untenable":

> "These provisions [ORS 656.262(4) and OAR 436-60-150(5)(a)], read in combination with ORS 656.262(2), previously quoted, provide for continuous compensation payments, ceasing only when the claim is denied or an order modifies or extinguishes the duty to pay. *See Georgia-Pacific v. Hughes*, [305 Or 286, 293, 751 P2d 775 (1988)]. This interpretation necessarily requires that compensation awarded in a determination order be paid pending a hearing on the extent of disability.
>
> "The second reason for rejecting the conclusions of the Board, as adopted by Georgia-Pacific, is found in *SAIF v. Maddox*, 295 Or 448, 667 P2d 529 (1983). *Maddox* addresses whether the Evaluations Division has jurisdiction to determine the extent of a claimant's disability before the issue of compensability is determined on appeal. *Former* ORS 656.313 was controlling. *Maddox* holds that
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> "'[ORS 656.313(4)] clarifies the intent of the legislature to include within the "compensation" that shall not be stayed under subsection (1) *awards determining the extent of disability*. By providing that *payment of disability in any degree shall not be stayed*, the legislature must have necessarily intended that a determination of extent of disability would not be stayed pending an appeal of compensability, for that would effectively defeat the purpose of subsection (1).' 295 Or at 454 (emphasis added).
>
> **127 Or App 352>** "A determination order is clearly an 'award determining the extent of disability.' *Maddox* did not limit its holding to cases in which the insurer appeals, nor is the quoted language limited to awards pending Board review or court appeal. Implicit in this reasoning is the conclusion that payments awarded in a determination order must continue until a referee or appellate body orders otherwise.
>
> "* * * * *
>
> "We are not persuaded that such a result indicates that the legislature contemplated a procedure other than paying the award of the determination order pending a hearing. * * *
>
> "* * * * *
>
> "Contrary to the argument of Georgia-Pacific, neither ORS 656.262(2) nor ORS 656.313 authorized Georgia-Pacific to terminate payments of compensation awarded in the determination order." 305 Or at 503. (Footnotes omitted.)

Piwowar is instructive, because it confirms that, under the existing statutory scheme, a determination order was the vehicle for awarding payment of compensation, and its effectiveness was not stayed because the employer challenged the compensability of the injury.

In 1990, the legislature made extensive amendments to the Workers' Compensation Law. One goal was to reduce the number of hearings before the Board regarding determination orders. To that end, the legislature amended ORS 656.268(4) to require a worker who objects to claim closure to seek reconsideration before the Department of Insurance and Finance (DIF) (now the Department of Consumer and Business Services), and to authorize requesting a hearing "[i]f any party objects to the reconsideration order" issued by DIF. ORS 656.268(6)(b).

The legislature also amended ORS 656.313(1)(a) to provide:

> "Filing by an employer or the insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed, except for:

"(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS <127 Or App 352/353> 656.268, or until the order appealed from is itself reversed, whichever event first occurs; and

"(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed."

To discern the legislature's intention in enacting that amendment, we look first to the text and context of the amendment. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The context of a statute includes other provisions of the same statute as well as other related statutes. *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611.

Claimant contends that the acts listed in ORS 656.313(1)(a) that stay "payment of the compensation appealed" refer to "hearings and subsequent administrative and judicial proceedings which follow from a Request for Reconsideration." I agree. A referee's order that concludes that an injury is compensable is not an order for the "payment of the compensation." A referee's order requires claim processing, not a payment of compensation. Employer was ordered to make a "payment of the compensation," within the meaning of ORS 656.313(1)(a), in the determination order, but failed to appeal from or seek reconsideration of that order. The Board correctly concluded that that order became final and enforceable, and that employer was not entitled to a stay under ORS 656.313(1)(a) merely because it challenged the referee's compensability finding.

The majority rejects claimant's argument because *Georgia-Pacific v. Piwowar, supra,* on which she relies, was decided under the former version of ORS 656.313. 127 Or App at 349. That response sweeps with too broad a brush. The legislature did not "overrule" *Piwowar* or modify its conclusion that a final determination order is enforceable, despite an employer's attempt to challenge the compensability of the injury.

The majority finds support in a later Board decision, *Felipe A. Rocha,* 45 Van Natta 47 (1993). Although I do not pass on the correctness of the *Rocha* order, it is noteworthy that that order was based on the following premise:

127 Or App 354> "In essence, when a 'compensability' appeal remains pending and 'pre-litigation order' temporary disability is being stayed, the subsequent claim closure order that awards 'pre-litigation order' temporary disability is granting the benefits on a conditional basis." 45 Van Natta at 49.

I am aware of no statutory or other authority that permits the Board to construe a final determination order as a mere conditional grant of compensation. That view disregards numerous cases that confirm that a final determination order that awards disability compensation is enforceable according to its terms. *Georgia-Pacific v. Piwowar, supra,* 305 Or at 503; *Georgia-Pacific v. Hughes,* 305 Or 286, 293, 751 P2d 775 (1988); *SAIF v. Maddox,* 295 Or 448, 454, 667 P2d 529 (1983).

The majority's result permits an employer to disregard a determination order that is final and enforceable on its face, simply because the employer has requested a hearing or filed an appeal regarding an adverse compensability finding. In effect, the majority's decision stays payment of compensation to claimants in every case in which there is an unresolved compensability issue before the Board or the appellate courts. In my view, the Board was correct in rejecting that unwarranted construction of ORS 656.313(1)(a).

I respectfully dissent.

Cite as 127 Or App 458 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jay A. Nero, Claimant.

JAY A. **NERO**, Petitioner,
v.
CITY OF TUALATIN, Respondent.
(92-04986; CA A80583)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 12, 1994.
Daniel J. DeNorch argued the cause for petitioner. On the brief was Michael R. Dehner.
Patric J. Doherty argued the cause for respondent. With him on the brief were Karli L. Olson and VavRosky, MacColl, Olson, Doherty & Miller, P.C.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
EDMONDS, J.
Reversed and remanded for reconsideration.

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127 Or App 460> Claimant seeks review from an order of the Workers' Compensation Board. He assigns error to the Board's decision not to award a penalty under ORS 656.268(4)(g), which provides:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

We reverse.

Claimant suffered a work related injury in March, 1991, that affected his lower back and right leg. In November, 1991, employer issued a Notice of Closure that found no permanent disability. ORS 656.268(4)(a).[1] Claimant requested reconsideration by the Department of Insurance and Finance (DIF), ORS 656.268(4)(e),[2] and sought a penalty pursuant to ORS 656.268(4)(g). The order on reconsideration granted claimant an unscheduled award of 12 percent, which was equivalent to a 38.40 degree loss for his back, and a scheduled award of 11 percent, which was equivalent to a 16.50 degree loss for his right leg. The order on reconsideration did not award a penalty.

127 Or App 461> Subsequently, employer requested a hearing. ORS 656.268(6)(b).[3] At that

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[1] In 1991 ORS 656.268(4)(a) provided:

> "When the worker's condition resulting from an accepted disabling injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment, the claim may be closed by the insurer or self-insured employer, without the issuance of a determination order by the Department of Insurance and Finance."

In 1993, the legislature changed the name of DIF to the Department of Consumer and Business Services. Or Law 1993, ch 744, section 18.

[2] ORS 656.268(4)(e) provides:

> "If the worker objects to the notice of closure, the worker first must request reconsideration by the department under this section."

[3] ORS 656.268(6)(b) provides, in part:

> "If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 180 days after copies of notice of closure or the determination order are mailed, whichever is applicable."

hearing, claimant renewed his request for a penalty under ORS 656.268(4)(g).[4] The referee reduced claimant's unscheduled award to 5 percent and eliminated the scheduled award. On review, the Board reinstated the award provided for in DIF's order. It, too, denied claimant's request for a penalty. It noted that, although the separate awards are less than 20 percent each, together they are equivalent to 23 percent permanent disability. It then framed the issue as whether the scheduled and unscheduled awards could be combined in order to achieve the 20 percent permanent disability requirement for a penalty under ORS 656.268(4)(g).

The Board concluded that ORS 656.268(4)(g) is ambiguous. It said:

> "We do not find that the statute clearly and unambiguously resolves the question, since it does not address the situation where 20 percent permanent disability may be achieved by a combination of scheduled and unscheduled awards."

When the legislative history proved unhelpful, the Board looked to the director's rules concerning the reconsideration process. Ultimately, it relied on OAR 436-30-050(13), which provides that, for the purpose of assessing a penalty under ORS 656.268(4)(g),

> "a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20% disabled."

Although the Board acknowledged that there could be circumstances in which the director's rule could be inconsistent with the statute, the Board used it as a basis for its analysis in **<127 Or App 461/462>** this case.[5] It then concluded that, because the sum of claimant's scheduled and unscheduled disability was 54.9 degrees, he was not entitled to a penalty.

We review the Board's order on review to determine whether it correctly interpreted the statute. ORS 656.298; ORS 183.482(8)(a); *PGE v. Bureau of Labor and Industries*, 317 Or 606, 608, 859 P2d 1143 (1993). In *PGE v. Bureau of Labor and Industries, supra*, the court provided an analytical framework for interpreting a statute. In determining the intent of the legislature, we are to examine both the text and context of the statute. The court went on to say:

> "In this first level of analysis, the text of the statutory provision itself is the starting point for interpretation and is the best evidence of the legislature's intent. In trying to ascertain the meaning of a statutory provision, and thereby to inform the court's inquiry into legislative intent, the court considers rules of construction of the statutory text that bear directly on how to read the text. Some of those rules are mandated by statute, including, for example, the statutory enjoinder 'not to insert what has been omitted, or to omit what has been inserted.' ORS 174.010. Others are found in the case law, including, for example, the rule that words of common usage typically should be given their plain, natural, and ordinary meaning." 317 Or at 610. (Citations omitted.)

The parties agree that DIF's order increased by 25 percent or more the amount of compensation for permanent disability. Claimant asserts that the language of the statute "indisputably covers situations [when] more than one award combines to meet the requirement of 20 percent disability, or [when] scheduled and unscheduled awards combine to meet the requirement of 20 percent disability" and argues that there is no "hint of ambiguity" in the statute. Employer argues that the statute is ambiguous because it "does not address the situation [of when the] 20 percent permanent disability may be achieved by a combination of scheduled and unscheduled awards."

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[4] The parties do not address, and we express no opinion about whether a claimant who has not objected to the order on reconsideration by requesting a hearing under ORS 656.268(6)(b) can, during the hearing requested by the employer, raise the issue of an ORS 656.268(4)(g) penalty that was not awarded in the order on reconsideration.

[5] Neither party challenges the validity of OAR 436-30-050(13), and we do not decide that question.

We perceive no ambiguity in the language of ORS 656.268(4)(g). ORS 656.005(6) defines a claim as a written **<127 Or App 462/463>** request for compensation. Under ORS 656.005(8), "compensation" includes all benefits for a compensable injury. A "compensable injury" is an injury arising out of and in the course of employment requiring medical services or resulting in disability or death. ORS 656.005(7). ORS 656.268(4)(g) unambiguously refers to a "claim" and to "compensation" and does not qualify those words in any respect. Therefore, they must be given their complete meaning within the context of the Workers' Compensation Act. That means the word "compensation" in ORS 656.268(4)(g) necessarily entails all of the compensation awarded as part of a claim. That construction is supported by the rest of the statute, which mandates that the amount of the penalty be based on "all compensation determined to be then due to claimant." In this case, the compensation awarded for the claim was for both scheduled and unscheduled disability. Thus, when the legislature said that "the worker is found upon reconsideration to be at least 20 percent permanently disabled," it intended to refer to the entire claim, including combined awards for scheduled and unscheduled disability.

Reversed and remanded for reconsideration.

Cite as 127 Or App 478 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Eileen N. Ferguson, Claimant.

EILEEN N. **FERGUSON**, Petitioner,
v.
U.S. EPPERSON UNDERWRITING and UNIVERSAL UNDERWRITER INS., Respondents.
(91-08692; CA A77177)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 2, 1993.
Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.
Richard Pearce argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed.

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127 Or App 480> Claimant seeks review of a Workers' Compensation Board order awarding her unscheduled permanent partial disability (PPD) benefits. She argues that the Board rated her disability under invalid temporary rules concerning disability rating standards, and that the Board erred in finding that it lacked authority to determine the validity of those rules. We do not reach the merits of claimant's challenge. We hold, instead, that her challenge to the temporary rules is moot and affirm on that basis.

In October and November of 1990, the Department of Insurance and Finance (DIF) adopted temporary rules concerning disability rating standards, which took effect immediately. By operation of law, the temporary rules were scheduled to expire on May 19, 1991. ORS 183.335(6)(a). Two months before that date, however, DIF adopted permanent rules concerning disability rating standards, which include the following provisions (OAR 436-35-003(1) and (2)):

> "(1) These rules apply to the rating of permanent disability pursuant to [ORS] chapter 656 and shall be applied to all claims closed on or after April 1, 1991, for workers medically stationary after July 1, 1990. For workers medically stationary prior to July 1, 1990, Administrative Order 6-1988 shall apply to the rating of permanent disability.
>
> "(2) For claims in which the worker was medically stationary after July 1, 1990, the Appellate Unit shall apply the disability rating standards in effect on the date of issuance of the Determination Order or Notice of Closure."

Claimant compensably injured her lower back and legs on March 7, 1990. By a Determination Order dated December 12, 1990, her claim was closed, and she received an award of 17 percent unscheduled PPD. An Order on Reconsideration dated June 21, 1991, increased the award of unscheduled PPD to 21 percent, in accordance with the temporary rules. Claimant requested a hearing, at which she challenged the validity of the temporary rules. In an opinion and order dated October 28, 1991, the referee held that he was obligated to apply the disability standards in effect at the time the claim was closed by Determination Order which, in this case, were the temporary rules. He held that he lacked authority to declare those rules invalid. Accordingly, he **<127 Or App 480/481>** applied them and arrived at an award of 25 percent unscheduled PPD. The Workers' Compensation Board affirmed, finding that it lacked authority to consider the validity of the temporary rules. On review, claimant's sole assignment of error is that the Board does have authority to rule on the validity of the temporary rules.

In *Edmundson v. Dept. of Ins. and Finance*, 314 Or 291, 838 P2d 589 (1992), the petitioner challenged the validity of the same temporary rules under ORS 183.400. He argued that, although the temporary rules had expired, the permanent rules still incorporated them by reference, and that reference to the temporary rules rendered them amenable to challenge. The court rejected the petitioner's argument and held that his challenge to the temporary rules was moot. The court observed that, although the permanent rules referenced the expired temporary rules,

> "*it is that cross-reference in the present rule that establishes the applicable law.* That is, *all* claims are governed by the *present permanent rule*, not the former temporary ones. If there is an invalid or indeterminate cross-reference in the present rule, that is a problem with the present rule, not with any past rules.
>
> "The former temporary rules have now passed out of existence, and no one presently purports to be acting pursuant to any power originating in them. A challenge to those temporary rules is, therefore, moot." 314 Or at 295. (Emphasis in original; citations omitted.)

In this case, the Board's rules required the application of the disability rating standards in effect at the time the Order on Reconsideration was issued. OAR 438-10-010(2).[1] By that date, June 21, 1991, the temporary rules had expired, and the permanent rules were in effect. Those permanent rules required the application of what had been the temporary rules to claimant's case. Accordingly, as in *Edmundson*, no one acted pursuant to any power originating in the temporary rules. Those rules had passed out of existence. The Board **<127 Or App 481/482>** and the referee applied the temporary rules only insofar as they had been incorporated by the permanent rules. The case, therefore, is governed by the permanent rules, the validity of which claimant does not challenge. Claimant's sole challenge is directed at the temporary rules, which no longer exist. Her challenge to those rules is moot, and she asserts no other basis for reversing the Board's order.

Affirmed.

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[1] OAR 438-10-010(2) provides:

> For claims in which the claimant was medically stationary after July 1, 1990, the disability rating standards in effect on the date of issuance of the reconsideration order shall be applied at hearing and on review of the reconsideration."

Cite as 127 Or App 511 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

THOMAS **TENOLD**, Respondent,
v.
WEYERHAEUSER COMPANY, a corporation, and LARRY HOFF, Appellants.
(89-2198 CV; CA A72816)

In Banc*
Appeal from Circuit Court, Klamath County.
Rodger J. Isaacson, Judge.
Argued and submitted April 19, 1993; resubmitted in banc November 3, 1993.
Jeffrey M. Batchelor argued the cause for appellant Weyerhaeuser Company. Alan M. Scott argued the cause for appellant Larry Hoff. With them on the briefs were James H. Clarke and Lane, Powell, Spears, Lubersky, and Galton, Scott & Colett.
George W. Kelly argued the cause and filed the brief for respondent.
DURHAM, J. pro tempore.
Affirmed.
Edmonds, J., concurring in part, dissenting in part.
*Haselton, J., not participating

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127 Or App 513> Defendants appeal a jury verdict entered against them for $2,552,566. They make multiple assignments of error. We affirm.

Plaintiff filed three claims against defendant Weyerhaeuser Company (Weyerhaeuser): malicious prosecution, intentional infliction of severe emotional distress and defamation. The jury found for plaintiff and awarded $900,000 noneconomic damages, $2,566 economic damages and $1,500,000 punitive damages against Weyerhaeuser on those claims. The jury found defendant Hoff liable on plaintiff's claims of intentional infliction of severe emotional distress and defamation and awarded $100,000 noneconomic damages and $50,000 punitive damages against Hoff.

In its first two assignments of error,[1] Weyerhaeuser argues that the trial court erred in denying its motions to withdraw from the jury the issue of its vicarious liability for Klamath County Sheriff Deputy Wilson's conduct. We review the evidence in the light most favorable to plaintiff to determine if there was sufficient evidence to submit the issue to the jury. *Turman v. Central Billing Bureau, Inc.*, 279 Or 443, 445, 568 P2d 1382 (1977).

Weyerhaeuser owns and operates a railroad as part of its business in Klamath County. Plaintiff worked for Weyerhaeuser for 12 years as a member of a section crew on the railroad. Defendant Hoff is a security supervisor, whose duties include investigating thefts of company property. Weyerhaeuser and the Klamath County sheriff's office entered into a contract under which Klamath County provided "Forestry Patrol and field investigation on Weyerhaeuser's property." Klamath County Sheriff Deputy Wilson carried out the county's responsibilities under the contract. Weyerhaeuser also hired Green, a private security guard, to live on its property and to provide 24-hour security.

On July 6, 1988, plaintiff asked Hoff if he could "get some railroad ties." Hoff told him it was "no problem," and instructed him to inquire of the company how much they **<127 Or App 513/514>** would cost. The next day, plaintiff asked Hoff if he could use some company equipment to pick up the ties, and Hoff said "that would be fine." On July 15, 1988, Green informed Hoff that plaintiff had delivered railroad ties to a cattle ranch. Hoff reported to Walt Barnes, his immediate supervisor, and to Steve Kirk, a security supervisor, that he suspected that plaintiff had stolen the ties delivered to the ranch. Kirk then contacted Wilson and asked him to investigate. While Wilson was interviewing the owner of the ranch, he told the owner that plaintiff had stolen 600 ties and sold them to others "around the country." While being interviewed by Hoff, two of plaintiff's co-workers said that they had helped plaintiff load some ties, and that plaintiff had told them that he intended to pay for the ties. Hoff did not tell his supervisor or Wilson about the information.

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[1] Some assignments are made by Weyerhaeuser alone; some are made by both defendants.

Shortly after his investigation began, Wilson went to plaintiff's home and told him that "it didn't look good" and that if he would admit guilt, he would not be arrested in front of his family. Plaintiff claimed that he had permission to take the ties. On August 1, plaintiff, Hoff, Barnes and a union representative met. Plaintiff admitted taking some ties but repeatedly maintained that Hoff had given him permission. After the meeting, Barnes met with his supervisor, McClure, and told him that plaintiff "had taken ties, and that he really offered no excuses or reasons for taking the ties without paying for them." Based on that information, Weyerhaeuser terminated plaintiff's employment.

At about the same time, Wilson issued plaintiff a criminal citation for theft in the second degree, and Kirk asked the district attorney to prosecute plaintiff. Wilson's report to the district attorney did not disclose plaintiff's contention that Hoff had given him permission to take the ties with the understanding that he would pay for them at a later time. Plaintiff was indicted by the Klamath County grand jury. Subsequently, the district attorney moved to dismiss the indictment after learning that some of the ties that plaintiff had been accused of stealing did not belong to Weyerhaeuser, and that plaintiff had paid for them.

There was also evidence in the record that Hoff and other employees at Weyerhaeuser had ill will toward plaintiff. An employee testified that Hoff told him, sometime in 1986, **<127 Or App 514/515>** that "there's more than one way to get rid of [plaintiff]." Kirk testified that a Weyerhaeuser manager who was involved in the investigation said, "I don't care what the court system does or anything else, that I -- I will have the man's job." Kirk also recalled in his testimony that Hoff had come to him after the charges against plaintiff were dropped and said that he had caught plaintiff in possession of marijuana a couple of years ago, that plaintiff was a drug addict, and that he wanted plaintiff "gone." Hoff's foster son testified that he overheard Hoff tell his wife that plaintiff was a drug user who had a methamphetamine lab in his house, and that he was always drunk at work. Plaintiff denied those allegations at trial.

Weyerhaeuser asserts that the trial court erred when it submitted the issue to the jury of whether Wilson was "its agent when he engaged in the conduct the jury ultimately found to be tortious." Weyerhaeuser's vicarious liability for Wilson's conduct depends on whether Wilson was an "employee" of Weyerhaeuser and committed the alleged tortious acts within the scope of his employment.[2] *Stanfield v. Laccoarce*, 284 Or 651, 654, 588 P2d 1271 (1978). Although the parties agree that Wilson was an employee of the county, in addition, he could be a "loaned" employee of Weyerhaeuser, if Weyerhaeuser had the right to exercise control over the manner and means by which Wilson performed his duties. *See Penrose v. Mitchell Bros.*, 246 Or 507, 512, 426 P2d 861 (1967); *Nordling v. Johnston*, 205 Or 315, 332, 283 P2d 994, 287 P2d 420 (1955); *Nichols v. Baggarley*, 79 Or App 505, 508, 719 P2d 914 (1986).

The contract between Klamath County and Weyerhaeuser says:

> "[Weyerhaeuser] may increase, decrease or alter work to be done and materials furnished hereunder, and any changes occasioned thereby in amounts to be paid hereunder shall be agreed to in writing prior to performance of such work or furnishing such materials. * * * All work or materials furnished hereunder shall at all times be subject to the inspection and approval of [Weyerhaeuser]."

127 Or App 516> That language could be construed to indicate that the parties intended that Wilson was the employee of Klamath County only and Weyerhaeuser is not liable vicariously for Wilson's conduct, as defendants argue. However, because the provision says that Weyerhaeuser has the right to "increase, decrease or alter the work to be done and the materials furnished" and the right to inspect and approve the work, it is also subject to the interpretation that Weyerhaeuser had the right to control the manner and means that Wilson used to accomplish the results sought by Weyerhaeuser. Those alternative interpretations demonstrate the ambiguity in the agreement, and the meaning of an ambiguous contract is an issue to be decided by the trier of fact. *David M. Scott Const. v. Roush*, 273 Or 877, 880, 544 P2d 162 (1975).

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[2] Defendants do not argue that Wilson was not acting within the scope of his employment when the alleged tortious conduct occurred.

Also, what the parties intended under the contract often is discernible by their conduct in carrying out the terms of the contract. *See Tarlow v. Arntson*, 264 Or 294, 300, 505 P2d 338 (1973). Wilson testified that Kirk asked him to investigate and told him who to contact. Wilson also testified that he kept Kirk updated on the progress of his investigation and gave him a copy of his report. Kirk testified that Weyerhaeuser had "control" of the investigation and that, whenever it had a problem to investigate, the deputy was at his "disposal." There was also a handwritten statement by Wilson that said that the "reason [the criminal prosecution] was dropped was per Steve Kirk's decision." We conclude that from the entire evidentiary record, the jury could have found that Weyerhaeuser had the right of control over Wilson's conduct such as to constitute a master-servant relationship. *See Meskimen v. Larry Angell Salvage Company*, 286 Or 87, 592 P2d 1014 (1979).

In their third and fourth assignments of error, both defendants contend that the trial court erred in denying their motions for directed verdict on plaintiff's claims for intentional infliction of severe emotional distress. They argue that plaintiff did not present any evidence to prove that defendants' conduct was an extraordinary transgression of the bounds of socially tolerable conduct. To prove a claim for intentional infliction of severe emotional distress, plaintiff must prove that:

> **127 Or App 517>** "(1) the defendant intended to inflict severe emotional distress on the plaintiff, (2) the defendant's acts were the cause of the plaintiff's severe emotional distress, and (3) the defendant's acts constituted an extraordinary transgression of the bounds of socially tolerable conduct." *Sheets v. Knight*, 308 Or 220, 236, 779 P2d 1000 (1989).

It is a question of law whether, viewing the evidence in the light most favorable to plaintiff, defendants' conduct constitutes "extraordinary conduct which a reasonable jury could find beyond the farthest reaches of socially tolerable behavior." *Hall v. The May Dept Stores*, 292 Or 131, 137, 637 P2d 126 (1981).

In *Hall v. The May Dept. Stores, supra*, the plaintiff was suspected of stealing money and was interrogated based on "scant" evidence. The court said that

> "the jury could find that [the security officer] knew that he did not have 'proof' of plaintiff's guilt, that he knew he did not have evidence sufficient to have her arrested, that he nevertheless told her that he had sufficient proof to have her arrested and charged with embezzlement, and that he shouted at plaintiff and pounded the desk, referring to sheets of paper which he did not explain to her." 292 Or at 141.

From this evidence, the court held that the jury could infer that the security officer was engaging in a deliberate and systematic tactic to threaten and frighten the plaintiff into a confession and to make her an example to other employees. The court said that,

> "if a jury, drawing all possible inferences favorable to plaintiff, found an intentionally oppressive method of browbeating an employee into a confession, it could also decide that this method went beyond the outer bounds of socially tolerable employer practices." 292 Or at 142.

Furthermore, in *Woods v. First American Title Ins. Co.*, 102 Or App 343, 348, 794 P2d 454 (1990), *rev den* 311 Or 151 (1991), we said that

> "[f]alsely accusing someone of being a liar, a thief and a fraud before a third person, knowing that the accusations are not true, and persuading a police officer to harass the accused person on the basis of those assertions, constitute more than every-day rude behavior."

127 Or App 518> We concluded that the plaintiff's complaint stated a claim for intentional infliction of severe emotional distress.

Here, the crux of plaintiff's claims for intentional infliction of severe emotional distress is that employees at Weyerhaeuser intentionally and in bad faith made accusations that plaintiff had stolen the ties, despite having knowledge that he was given permission to take them and that he intended to pay for them. The jury could infer that Hoff knew that plaintiff had permission to take the ties, but that he, along with other Weyerhaeuser employees, triggered an unfounded criminal investigation to get plaintiff fired, to defame him, and to cause him to be prosecuted by the district attorney. We hold that a jury

reasonably could find that defendants' conduct exceeded the bounds of socially tolerable conduct under the circumstances. Therefore, the trial court did not err in denying defendants' motion for directed verdict on plaintiff's claims for intentional infliction of severe emotional distress.

Next, Weyerhaeuser assigns as error the trial court's denial of its motion to modify the judgment to reduce the amount awarded to plaintiff for noneconomic damages to $500,000 in accordance with ORS 18.560. The jury awarded plaintiff a total of $900,000 in noneconomic damages on his three claims against Weyerhaeuser.[3] Plaintiff argues that, although ORS 18.560 limits his recovery for noneconomic damages to $500,000 per claim, he may recover more than $500,000 in noneconomic damages, because he prevailed on more than one claim. Weyerhaeuser argues that the limitation on damages in the statute means that the total award of noneconomic damages for all tort claims arising out of the same operative facts cannot be more than $500,000.

In construing statutes, our task is to discern the intent of the legislature. ORS 174.010; *Mattiza v. Foster*, 311 Or 1, 4, 803 P2d 723 (1990). We first look to the text of the statute to ascertain "what is * * * contained therein, not to insert what has been omitted, or to omit what has been inserted." ORS 174.010; *Sanders v. Oregon Pacific States* **<127 Or App 518/519>** *Ins. Co.*, 314 Or 521, 527, 840 P2d 87 (1992). If the meaning of the statute is not apparent on its face, we look to the statute's context, and if that is not dispositive, then we examine its legislative history. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993).

ORS 18.560 provides, in part:

> "Except for claims subject to ORS 30.260 to 30.300 and ORS chapter 656, in any *civil action* seeking damages arising out of bodily injury, including emotional injury or distress, death or property damage of *any one person* * * *, the amount awarded for noneconomic damages shall not exceed $500,000." (Emphasis supplied.)

The language of ORS 18.560 limits noneconomic damages to $500,000 in any "civil action." We cannot ascribe a plain meaning to the phrase "civil action," because "action" has been interpreted in a variety of ways. *See East Side Mill Co. v. SE Portland Co.*, 155 Or 367, 372, 64 P2d 625 (1937). Likewise, the statute's context is not dispositive and we find no express legislative history to indicate what the legislature meant by the phrase.[4] In the absence of such evidence, we will consider the objective of the statute to determine the legislative intent. *See State v. Parker*, 299 Or 534, 540, 704 P2d 1144 (1985).

ORS 18.560 was enacted as part of the 1987 "Tort Reform Act." Or Laws 1987, ch 774, 6. According to the legislative history, the purpose of imposing a cap on noneconomic damages was to stabilize insurance premiums and to decrease the costs associated with tort litigation. Minutes, House Judiciary Subcommittee, April 29, 1987, pp 11, 15. In the light of that purpose, we are persuaded that the modern definition of an "action," adopted by the Supreme Court in *Dean v. Exotic Veneers, Inc.*, 271 Or 188, 193, 531 P2d 266 (1975), best fulfills the objective of the statute:

> **127 Or App 520>** "The most convenient [definition] is to consider a cause of action as an *aggregate of operative facts* giving rise to a right or rights termed 'right' or 'rights of action' which will be enforced by the courts. The number and extent of operative facts included within a single cause of action are to be determined pragmatically, mainly by considerations of practical trial convenience." (Emphasis supplied.)

The relevant factors for determining what connotes an "aggregate of operative facts" are "their relatedness in time, space, origin, or motivation, and whether, taken together they form a convenient unit for trial purposes." *Troutman v. Erlandson*, 287 Or 187, 206, 598 P2d 1211 (1979). In this case, plaintiff's factual allegations about Weyerhaeuser's course of conduct are an aggregate of operative facts

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[3] The jury awarded plaintiff $250,000 in noneconomic damages on his claim for malicious prosecution, $500,000 for his claim for intentional infliction of severe emotional distress, and $150,000 for his claim of defamation.

[4] A preliminary version of ORS 18.560 said that "the amount awarded for noneconomic damages shall not exceed $500,000 per person in the aggregate." During its first work session, the legislature deleted the phrase "per person in the aggregate," because it found the language to be confusing. Chairman Frye said that the committee's intention was to limit damages to $500,000 per person and that the language that limits damages of any one person sufficiently reflected that intention. There was no discussion of multiple claims. Tape Recording, Senate Committee on Judiciary, March 23, 1987, Side A at 355-416.

that give rise to several "rights of action." We conclude that the statute directs the trial court to reduce the noneconomic damage award to $500,000.

However, plaintiff contends that ORS 18.560 violates Article VII (amended), section 3, of the Oregon Constitution, which provides, in part:

> "In actions at law, where the value in controversy shall exceed $200, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any court of this state, unless the court can affirmatively say there is no evidence to support the verdict."

"Reexamine" means to subject to "a second or new examination." *Websters Third New International Dictionary* 1907 (unabridged 1976). We cannot discern from the text and context of Article VII (amended), section 3, whether a court "re-examines" a "fact tried by a jury" when it reduces a damage award that exceeds the statutory limit. *See Comeaux v. Water Wonderland Improvement Dist.*, 315 Or 562, 570, 847 P2d 841 (1993). To resolve that question, we look for guidance to the circumstances surrounding the adoption of Article VII (amended), section 3. *See PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611.

Van Lom v. Schneiderman, 187 Or 89, 98, 210 P2d 461 (1949), discusses the evolution of Article VII (amended), section 3. The framers of the United States Constitution preserved the right of trial by jury, as it was know at common law, in the Seventh Amendment, which provides:

127 Or App 521> "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."

That amendment protected the jury trial right as it had developed in England. At the time of the adoption of the Seventh Amendment, English common law reserved to the jury the determination of the amount of damages. 3 W. Blackstone, Commentaries 396. However, the English system authorized the court, in a damage action, to grant a new trial if the judge believed that the verdict awarded excessive damages. *Van Lom* says that

> "the federal judges, like the English judges, have always exercised the prerogative of granting a new trial when the verdict was clearly against the weight of the evidence, whether it be because excessive damages were awarded or for any other reason." 187 Or at 112.

Oregon preserved that federal jury trial right when it adopted Article I, section 17, as part of its Bill of Rights.[5] That section provides:

> "In all civil cases, the right of Trial by Jury shall remain inviolate."

Before 1910, Oregon also retained the tradition of allowing courts to set aside "excessive" verdicts. *Van Lom v. Schneiderman, supra*, 187 Or at 105. For example, OCLA, 5-802, authorized a new trial for:

> "(5) Excessive damages, appearing to have been given under the influence of passion or prejudice; (6) Insufficiency of the evidence to justify the verdict or other decision[.]"

See 187 Or at 105.

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[5] *Deane v. Willamette Bridge Co.*, 22 Or 167, 29 P 440 (1892), on which the dissent relies, 127 Or App at 532-533, held that the plaintiff had no constitutional right under Article I, section 17, of the Oregon Constitution, to a jury determination of damages in a default proceeding, because the English common law did not afford a jury trial right in a default proceeding. *Deane* is of limited utility here, because it was decided 18 years before the adoption of Article VII (amended), section 3, and this case does not concern rules applicable to default proceedings.

In 1910, the people of Oregon adopted Article VII (amended), section 3. The amendment repeats the substance of Article I, section 17, but also creates a limitation on the **<127 Or App 521/522>** authority of an Oregon court to reexamine a jury's determination of any fact, through the proscription: "no fact tried by a jury shall be otherwise re-examined in any court of this State." *Buchanan v. Lewis A. Hicks Co.*, 66 Or 503, 510, 133 P 780, 134 P 1191 (1913), describes the problem that the amendment was intended to correct:

> "Pursuant to the provisions of that statute [Lord's Oregon Laws, 174] it had been the practice of many trial courts in Oregon, prior to the amendment of the organic law * * * to set aside judgments and grant new trials, when, from a consideration of all the evidence given at the trial of an action, it was believed the verdict was excessive. In order to inhibit such practice and to uphold verdicts, the Constitution was amended so as to preclude a court from re-examining any fact that had been tried by a jury, when the verdict returned was based on any legal evidence * * *."

In *Van Lom v. Schneiderman, supra*, 187 Or at 95, the court said:

> "This last clause forbids re-examination of a fact found by a jury otherwise than by another jury * * *, and is transgressed every time that a court undertakes to revise or correct a jury's finding of fact (unless this be done by the Supreme Court where there is error in the record * * *). All that the court may do, so far as the facts are concerned, is to examine the record to determine whether it 'can affirmatively say there is no evidence to support the verdict.'"

The Supreme Court has held that the amendment was intended to prohibit courts from deciding that a jury's factual determination of the amount of damages is improper when measured against a statutory standard, such as "excessive," and nullifying the verdict.

> "The purpose of this amendment [Article VII, section 3] was to prohibit courts from setting aside or modifying judgments founded upon verdicts of juries, where there is no prejudicial error in the record. In this case the jury was properly instructed, and there is no assignment of error except as to the amount of the verdict. Under such circumstances, it was for the jury only to fix the amount of plaintiff's damages, which it did by a unanimous verdict.
>
> "* * * * *
>
> "Although in the opinion of this court the amount of damages awarded might be deemed excessive, we cannot affirmatively **<127 Or App 522/523>** say that there is no evidence to support it. Under the record in the case, this court is powerless to grant relief." *Malpica v. Cannery Supply Co.*, 95 Or 242, 247, 187 P 596 (1920).

Malpica v. Cannery Supply Co., supra, is but one of many cases that hold that Article VII (amended), section 3, is a limitation on the court's power to set aside or modify a jury's factual determination of damages, or a judgment that embodies that determination, following a fair trial. In *Sigel v. Portland Ry. L. & P. Co.*, 67 Or 285, 291, 135 P 866 (1913), the court held that, after the plaintiff presented the evidence of her injury,

> "[i]t therefore became the duty of the jury to determine the amount of her damages. * * * The judgment on the verdict could not be set aside without the re-examination of a question of fact which had been tried by a jury upon legal evidence and under proper instructions as to the law."[6]

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[6] The determination of the amount of punitive damages is likewise a question of fact. *Van Lom v. Schneiderman, supra*, 187 Or at 111, discussing punitive damages, says:

> "Under a system such as ours, where the court responds to the law and the jury to the facts, it would be difficult indeed to say that a question which for centuries has been submitted to the decision of a jury is other than a question of fact. And the reluctance of the courts, having power to do so, to interfere with the jury's decision, gives added weight to this conclusion."

See also Hahn v. Mackey, 63 Or 100, 111, 126 P 12, 126 P 991 (1912).

Roach v. Mead, 301 Or 383, 385, 722 P2d 1229 (1986), states:

> "In *Shepler v. Weyerhaeuser Company*, 279 Or 477, 484, 569 P2d 1040 (1977), which concerned a jury verdict for plaintiff in a negligence action, we defined our scope of review in civil actions at law:
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> "'* * * Since the verdict was for plaintiff, we could not find error * * * unless we could affirmatively say there is no evidence to support the verdict. (Oregon Constitution, Amended Art. VII, 3.)'"

The Supreme Court has applied that limitation on appellate review authority since the earliest cases construing Article VII (amended), section 3.

> "[T]he Supreme Court, on appeal, is powerless to re-examine any fact tried by a jury, unless it, like the lower court, in passing upon a motion for a new trial, can affirmatively say there is no evidence to support the verdict. * * *

127 Or App 524> "[T]he right, upon appeal, to correct a judgment rests upon an error of law committed by the trial court and not upon the re-examination of any fact tried by a jury, except in cases where the Supreme Court can affirmatively say there is no evidence to support the verdict." *Buchanan v. Lewis A. Hicks Co.*, *supra*, 66 Or at 511.

Sullivan v. Wakefield, 65 Or 528, 535, 133 P 641 (1913), says:

> "Under this section of the Constitution, a court cannot legally set aside the findings of the jury, where there has been no error of law, without affirmatively finding that there was *no* evidence to support the verdict." (Emphasis in original.)

In *Love v. Chambers Lumber Co.*, 64 Or 129, 133, 129 P 492 (1913), the court said:

> "Where there is evidence to support a verdict, and the facts have been submitted to a jury under proper instructions, we are precluded from disturbing such verdict. Article VII, Section 3, of the constitution as amended November 8, 1910 * * *."

Similarly, the court said in State v. Hill, 63 Or 451, 459, 128 P 444 (1912):

> "Under the recent amendment to our constitution (Article VII, section 3), if there is any evidence to support the verdict, this court cannot disturb it. The jury are the exclusive judges of all questions of fact."

ORS 18.560 reinstitutes the practice of courts reducing excessive jury awards, except that it substitutes a statutory monetary standard, $500,000, for statutory criteria controlling judicial discretion (e.g., "excessive damages," "passion or prejudice," and "insufficiency of the evidence"). It requires the court to apply the monetary standard in every case, whether or not the evidence supports the jury's higher damage award. Article VII (amended), section 3, was designed to prevent that practice, because the people chose to make jurors the exclusive judges of the facts regarding the extent of a plaintiff's damages. We have examined the context of the adoption of Article VII (amended), section 3, and the problem that it sought to remedy. From our examination, we conclude that a jury's verdict on damages, which is supported by the evidence, is a "fact tried by a jury" under that amendment, and that ORS 18.560 violates that amendment, because it **<127 Or App 524/525>** compels the court to reexamine the verdict by requiring the court to nullify the jury's factual determination to the extent that it exceeds the legislature's damage cap.

Weyerhaeuser argues that its motion did not threaten any interference with the jury's factual determination on damages because ORS 18.560 operates as a limitation after the jury makes its award.[7]

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[7] The dissent relies on *Wiebe v. Seeley, Administrator*, 215 Or 331, 335 P2d 379 (1959), which interpreted a statutory limitation on wrongful death damages, for the proposition that, after the adoption of Article VII (amended), section 3, in 1910, "the legislature's authority to limit the amount of reasonable damages remained unfettered." 127 Or App at 534. *Wiebe* does not support that argument, because no party in Wiebe challenged the wrongful death statute under Article VII (amended), section 3. The court noted, "It is not suggested that such a statute is beyond the powers of the legislature." 215 Or at 353. *Wiebe* construes a statute, not a constitutional provision.

We give the same response to that argument as the Washington Supreme Court gave to it in *Sofie v. Fibreboard Corp.*, 112 Wash 2d 636, 655, 771 P2d 711, 780 P2d 260 (1989):[8]

> "Respondents also contend that the damages limit affects only the judgment as entered by the court, not the jury's finding of fact. This argument ignores the constitutional magnitude of the jury's fact-finding province, including its role to determine damages. Respondents essentially are saying that the right to trial by jury is not invaded if the jury is allowed to determine facts which go unheeded when the court issues its judgment. Such an argument pays lip service to the form of the jury but robs the institution of its function. This court will not construe constitutional rights in such a manner. As we once stated:
>
> "'The constitution deals with substance, not shadows. Its inhibition was leveled at the thing, not the name * * *. If the inhibition can be evaded by the form of the enactment, its insertion in the fundamental law was a vain and futile proceeding. *State v. Strasburg*, 60 Wash. 106, 116, 110 P. 1020 (1910), quoting *Cummings v. Missouri*, 71 U.S. (4 Wall.) 277, 325, 18 L. Ed. 356 (1866)'"

127 Or App 526> Weyerhaeuser also contends that, if the statute compels a reexamination of a fact found by the jury, courts are similarly barred from applying the statutes that govern contributory negligence, ORS 18.470,[9] and contribution, ORS 18.455.[10] Those statutes are not analogous because, under them, the court gives effect to the jury's findings on damages. Under ORS 18.470, the court carries out the jury's findings on the amount of the plaintiff's damages and the plaintiff's proportionate fault. Under ORS 18.455, the court reduces the damage award by the amount that the plaintiff has already recovered from a co-defendant to ensure that the plaintiff receives only the amount of damages found by the jury. In contrast, ORS 18.560 directs the court to nullify the jury's verdict on damages to the extent that the verdict exceeds the amount that the legislature has determined is a fair award in all cases, regardless of the jury's contrary determination from the evidence in a particular case.

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[8] *Sofie* held that a statutory limit on the noneconomic damages recoverable by a personal injury or wrongful death plaintiff infringed on the Washington state constitutional guarantee of the right to trial by jury. The court's opinion reports that that view reflects the weight of authority from other jurisdictions, particularly those states that have analyzed the history of the jury trial right. 112 Wash 2d at 659. On that point, Oregon's constitutional history is similar to that of Washington, except that Oregon, by enacting Article VII (amended), section 3, has expressed its constitutional policy on protecting jury verdicts from judicial reexamination more clearly than any other state.

[9] ORS 18.470 provides:

> "Contributory negligence shall not bar recovery in an action by any person or the legal representative of the person to recover damages for death or injury to person or property if the fault attributable to the person seeking recovery was not greater than the combined fault of the person or persons against whom recovery is sought, but any damages allowed shall be diminished in the proportion to the percentage of fault attributable to the person recovering. This section is not intended to create or abolish any defense."

[10] ORS 18.455 provides:

> "(1) When a covenant not to sue or not to enforce judgment is given in good faith to one of two or more persons liable in tort for the same injury or the same wrongful death or claimed to be liable in tort for the same injury or the same wrongful death:
>
> "(a) It does not discharge any of the other tortfeasors from liability for the injury or wrongful death unless its terms so provide; but it reduces the claim against the others to the extent of any amount stipulated by the covenant, or in the amount of the consideration paid for it, whichever is the greater; and
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> "(b) It discharges the tortfeasor to whom it is given from all liability for contribution to any other tortfeasor.
>
> "(2) When a covenant described in subsection (1) of this section is given, the claimant shall give notice of all of the terms of the covenant to all persons against whom the claimant makes claims."

Weyerhaeuser's motion invited the trial court to set aside the jury's verdict, because it was too large when measured by the damage cap in ORS 18.560. Article VII (amended), section 3, forbids the court to reexamine the verdict unless no evidence supports it. Because evidence in **<127 Or App 526/527>** the record supported the verdict, the court correctly refused to set it aside.[11]

Defendants' remaining assignments of error challenge the jury's punitive damages award. They assert that the award was excessive and, therefore, violated their rights under Article I, section 16, of the Oregon Constitution, the Eighth Amendment and the Due Process Clause of the Fourteenth Amendment to the United States Constitution.[12] They assign as error the denial of their motion for a new trial on that basis. ORCP 64B. In *Oberg v. Honda Motor Co.*, 316 Or 263, 275, 851 P2d 1084 (1993), *cert granted* ___ US ___, 114 S Ct 751, 127 L Ed 2d 69 (1994), the Supreme Court held that Article I, section 16, applies only to criminal cases, and that the award in that case did not violate the Due Process Clause under the holding in *Pacific Mut. Life Ins. Co. v. Haslip*, 499 US 1, 111 S Ct 1032, 113 L Ed 2d 1 (1991).[13] Similarly, Article I, section 16, does not apply in this case and the punitive damages award does not violate defendants' due process rights in the light of the court's instruction that outlined objective criteria on which the jury was required to base its decision,[14] and because of the availability of post-verdict review.

127 Or App 528> Regarding the Eighth Amendment, the United States Supreme Court held in *Browning-Ferris v. Kelco Disposal*, 492 US 257, 264, 109 S Ct 2909, 106 L Ed 2d 219 (1989), that the clause does not apply to awards of punitive damages in cases between private parties "when the government neither has prosecuted the action nor has any right to receive a share of the damages awarded." The Court left open the question we must answer in this case: whether the amendment applies to a civil action when the government has a right to share in the award. In reviewing the purpose and the

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[11] In *Rogers v. Hill*, 281 Or 491, 506, 576 P2d 328 (1978), Justice Tongue, joined by Justice Lent, in a special concurring opinion, said:

> "[A]lthough juries may sometimes make mistakes, so do judges, and the voters and legislature of Oregon, by the constitutional and statutory provisions adopted by them, made a deliberate choice to confer upon juries the exclusive and final authority to resolve such questions and to remove from the courts the power to either set aside such determinations by juries *or to withhold such questions from juries for determination*." (Emphasis supplied.)

We do not address whether Article VII (amended), section 3, forbids courts from withholding traditional factual issues, such as the amount of a plaintiff's damages in a tort action, from a jury and, if so, whether ORS 18.560 violates that obligation.

We also do not address other arguments concerning the constitutionality of ORS 18.560. For example, we do not address whether ORS 18.560 violates the duty of courts to administer justice "completely," within the meaning of Article I, section 10, because it compels the court to reduce a jury's damage award that the evidence supports.

[12] Plaintiff argues that defendants did not preserve their argument that the punitive damages award violated the prohibition against excessive fines under both the federal and the state constitutions. We disagree.

[13] *See also TXO Production Corp. v. Alliance Resources Corp.*, ___ US ___, 113 S Ct 2711, 125 L Ed 2d 366 (1993).

[14] The jury was instructed:

> "If you have found that Plaintiff is entitled to general damages, you must then consider whether to award punitive damages. Punitive damages may be awarded to the Plaintiff, in addition to general damages, to punish the wrongdoer and to discourage the Defendant and others from engaging in wanton misconduct. In considering punitive damages, you must first determine whether the Defendant was guilty of wanton misconduct that caused damage to Plaintiff. Wanton misconduct is conduct amounting to a particularly aggravated deliberate disregard of the rights of others. If you decide this issue against the Defendant, you may award punitive damages, although you are not required to do so, because punitive damages are discretionary. In the exercise of the discretion[,] you may consider the *importance to society of deterring similar misconduct* in the future. If you decide to award punitive damages, you may properly consider the following items in fixing the amount. First, the *character of the Defendant's conduct*. Second, the Defendant's *motive*. Third, the *sum of money that would be required to discourage* the Defendant and others from engaging in such conduct in the future. And fourth, the *income and assets* of the Defendant. The amount of punitive damages may not exceed the sum of $2,000,000 -- $1,000,000 on the malicious prosecution, and $1,000,000 on the intentional infliction of emotional distress." (Emphasis supplied.)

history of the Eighth Amendment, it said that the framers were concerned with "the potential for governmental abuse of its 'prosecutorial' power" and that the Excessive Fines Clause was "intended to limit only those fines *directly imposed by*, and payable to, the government." 492 US at 266, 268. (Emphasis supplied.) Furthermore, it said that it

> "has never held, or even intimated, that the Eighth Amendment serves as a check on the power of a jury to award damages in a civil case. Rather, our concerns in applying the Eighth Amendment have been with the criminal process and with *direct actions initiated by government* to inflict punishment. Awards of punitive damages do not implicate these concerns." 492 US at 259. (Emphasis supplied.)

Under ORS 18.540,[15] the government becomes a beneficiary of a portion of a punitive damages award after a **<127 Or App 528/529>** verdict has been entered. In this case, a private party brought an action against defendants, and the jury directly imposed the judgment against defendants to punish and to deter future misconduct. The government of Oregon did not initiate this action. Because the purpose of the Eighth Amendment would not be furthered if applied under the circumstances, we reject defendants' arguments. The trial court did not err in denying their motion for a new trial.

Affirmed.

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[15] ORS 18.540 provides, in part:

> "Upon the entry of a judgment including an award of punitive damages, the Department of Justice shall become a judgment creditor as to the punitive damages portion of the award to which the Criminal Injuries Compensation Account is entitled pursuant to paragraph (c) of this subsection * * *."

EDMONDS J., concurring in part; dissenting in part.

I concur in the majority's opinion, except for the portion that holds that the limitation on noneconomic damages in ORS 18.560 is unconstitutional. The majority says that ORS 18.560 violates the prohibition in Article VII (amended), section 3, against the reexamination of a fact "tried by a jury," and thus, it invalidates the major component of the Oregon Tort Reform Law enacted in 1987. It rejects Weyerhaeuser's argument that the statute does not interfere with the jury's factual determination because the statute operates as a legal limitation after the jury makes its award on the basis of the reasoning of the court in *Sofie v. Fiberboard Corp.*, 112 Wash 2d 636, 771 P2d 711, 780 P2d 260 (1989). For the reasons that follow, the majority's reliance on that reasoning is ill-placed, and it errs when it declares the statute to be unconstitutional under section 3.

Sofie v. Fiberboard, supra, is about Article I, section 21, of the Washington Constitution, which provides that "the right of trial by jury shall remain inviolate."[1] Of course, **<127 Or App 529/530>**

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[1] The language "the right to trial by jury shall remain inviolate," is found also in the Bill of Rights, Article I, section 17, as originally adopted in the Oregon Constitution. In Oregon, the provision has been interpreted to mean the "right [to have] a jury determine *all issues of fact*." *Molodyh v. Truck Insurance Exchange*, 304 Or 290, 297, 744 P2d 992 (1987). (Emphasis supplied.) There are differing interpretations of whether a statutory limitation of the amount damages violates the "inviolate" right to trial by jury, depending on the jurisdiction. For instance, Article I, section 20 of the Indiana Constitution contains a provision identical to section 17 and Article I, section 21, of the Oregon Constitution. In *Johnson v. St. Vincent Hospital Inc.*, 404 NE2d 585 (Ind 1980), the appellants argued that an Indiana statute which limited damages in medical malpractice cases violated section 20. The court disagreed.

> "When a request is made to the trial court for an order to determine the amount due claimant from the patient's compensation fund after a trial by jury on the issue of damages has taken place and the trial court has rendered a judgment, no contest with regard to the total damages due claimant can or does exist. That issue has already been finally adjudicated by the trier of fact. * * * Furthermore, there is no indication in the cases relied upon by appellants that the right to have a jury assess the damages in a case properly tried by jury constitutes a limitation upon the authority of the Legislature to set limits upon damages. * * * It is the policy of this Act that recoveries be limited to $500,000, and to this extent the right to have the jury assess the damages is available. No more is required by Art. I, 20 of the Indiana Constitution in this context." 404 NE2d at 602.

In my assessment, the Indiana Supreme Court's opinion has no more relevance to the Oregon Constitution than the Washington Supreme Court's opinion.

Article VII (amended), section 3, has entirely different language. The *Sofie* court examined the right to trial by jury as it existed in Washington at the time of section 21's adoption in 1889. The court was persuaded by the decision in *Baker v. Prewitt*, 3 Wash Terr 595, 19 P 149 (1888):

> "Baker's holding provides clear evidence that the jury's fact-finding function included the determination of damages. This evidence can only lead to the conclusion that our constitution, in article 1, section 21, protects the jury's role to determine damages." *Sofie v. Fiberboard Corp., supra*, 112 Wash 2d at 646.

This court's adoption of the Sofie court's reasoning without regard to the discrete language and history of section 3 constitutes a "nonanalysis" of the issue. Moreover, as will be demonstrated later, the Washington court's construction of section 21 is inconsistent with our Supreme Court's construction of Article I, section 17, of the Oregon Constitution, although the language of the provisions is identical. Finally, the *Sofie* court's reasoning is flawed because it fails to recognize the difference between the jury's fact finding process and the imposition of a rule of law by a trial court subsequent to the jury's factual determination.

A proper analysis begins with the understanding that ORS 18.560 is presumptively constitutional, and that we cannot declare a law that the legislature has passed in the best interests of all of the citizens of Oregon unconstitutional except when the unconstitutionality is clearly shown. *See Bowden v. Davis et al*, 205 Or 421, 289 P2d 1100 (1955). The first step of the analysis is to examine the language of section **<127 Or App 530/531>** 3. It is presumed that the language used in section 3 is sufficiently precise to convey the intent of its framers.

> "To find the thought a given [constitutional provision] expresses, the first resort in all cases is to the natural signification of the words used * * *. If thus regarded the words embody a definite meaning, * * * there is no room for construction." *Monaghan v. School District No. 1, Clackamas County*, 211 Or 360, 367, 315 P2d 797 (1957).

The majority says that "'reexamine' means to subject to a 'second or new examination,'" but that it cannot discern "whether a court 're-examines' a 'fact tried by a jury' when it reduces a damage award that exceeds the statutory limit." 127 Or App at 519. I disagree, because the meaning of section 3 is plain from the language of the provision. "Facts are actualities." *See Churchill v. Meade*, 92 Or 626, 636, 182 P 368 (1919). A determination of an ultimate fact is a determination of what took place based on the underlying evidentiary facts and the inferences drawn therefrom. *See Maeder Steel Products Co. v. Zanello*, 109 Or 562, 570, 220 P 155 (1924). In contrast, the imposition of a rule of law by a court arises from a different source; from the mandate of a constitutional provision, a statute or the case law. Although a ruling of law by the court often "flows from the ultimate facts" as found by the trier of fact, it is uniquely within the province of the court and it does not involve the fact finding process. *State v. Cummings*, 205 Or 500, 532, 288 P2d 1036, (1955); *see also Can-Key v. Industrial Leasing*, 286 Or 173, 183, 593 P2d 1125 (1979).

Section 3 recognizes that difference. It prohibits the "reexamination of facts" tried by a jury but at the same time preserves the power of the court to set aside a verdict if there is no evidence to support it. That language demonstrates that the framers were cognizant of the difference between the fact finding process and the imposition of a rule of law dictated by the facts of a case. Section 3 does not prohibit the imposition of a rule of law that supersedes a determination of fact by a jury.

The next step is to determine whether the application of ORS 18.560 to a jury verdict constitutes "a reexamination of fact" or the imposition of a "rule of law." It is clear **<127 Or App 531/532>** that the determination by a jury about the amount of damages that a plaintiff has incurred as a result of a defendant's conduct is a determination of ultimate fact and implicates section 3. *See Chance v. Alexander*, 255 Or 136, 138, 465 P2d 226 (1970). For instance, if a jury determines that the plaintiff has incurred $600,000 in noneconomic damages, no court in Oregon could lawfully reexamine the evidence and substitute its finding that the plaintiff had incurred only $450,000 in damages for the jury's determination.

However, ORS 18.560 does not require the trial court to make a reassessment of the amount of damages, but requires the court to perform a different function. It says, "the amount awarded for

noneconomic damages shall not exceed $500,000," and requires the trial court to enter judgment for not more than that amount. No reevaluation of the amount of damages incurred by the plaintiff occurs. The statute establishes a fixed ceiling on the amount of damages for which a judgment could be entered. The effect of the statute is to impose a rule of law, a limit on "recoverable" damages on the jury's verdict. In that sense, the statute, in concept, is no different than other rules of law which require a trial court to enter a judgment that changes the decision of the jury, e.g., a directed verdict under ORCP 60, a judgment notwithstanding the verdict under ORCP 63, a reduction in an award of damages because of comparative negligence under ORS 18.470, or a judgment for treble damages for timber trespass under ORS 105.810. When the language of section 3 and ORS 18.560 are compared, logic tells us that the implementation of the statute does not involve the substitution of the court's determination of the amount of damages for that of the jury's.

Even if, because of an ambiguity in section 3, we are permitted to look further for the answer to the query, the majority's analysis is not helpful. None of the cases that it cites are about statutes that impose legal limitations on the amount of damages that are recoverable in a particular claim. All of them concern the setting aside of excessive verdicts on the basis that the trial judge did not agree with the jury's determination of the facts. We must keep in mind that section 3 is to be interpreted to give effect to the intent of the people adopting it in 1910. The majority is not permitted to rewrite **<127 Or App 532/533>** the constitution to outlaw ORS 18.560 unless the statute conflicts with what the people had in mind at that time. *Jones v. Hoss*, 132 Or 175, 178, 285 P 205 (1930). With those principles in mind, I examine the background underlying the adoption of section 3 and its historical relationship to Article I, section 17.

Inherent in the majority's holding is the belief that plaintiffs had a historical right to unlimited damages for personal injury at common law and that the legislature cannot constitutionally limit the amount of damages that could be awarded in a personal injury action. That belief is mistaken. At common law, the courts could control excessive verdicts. They could order a new trial "when the verdict was clearly against the weight of the evidence, whether it be because excessive damages were awarded or for any other reason." *See Van Lom v. Schneiderman*, 187 Or 89, 112, 210 P2d 461 (1949). When the constitution was adopted, the founding fathers did not intend to create an enhanced right to trial by jury, but instead intended that the practice of the courts at the time continue. *See Tribou v. Strowbridge*, 7 Or 156, 158 (1879).

If courts could control the award of damages under section 17, the legislature could also. For instance, in 1862, the legislature authorized courts to set aside verdicts and grant new trials because of "[e]xcessive damages * * * given under the influence of passion or prejudice." *See* General Laws of Oregon, ch 2, 232(5), p 197 (Civ Code) (Deady 1845-1864). More importantly, also in 1862, the legislature enacted a statute which limited the amount of recoverable damages in a wrongful death action:

> "When the death of a person is caused by the wrongful act or omission of another, the personal representatives of the former may maintain an action at law therefor against the latter, if the former might have maintained an action, had he lived, against the latter, for an injury caused by the same act or omission. Such action shall be commenced within two years after the death, and the damages therein shall not exceed five thousand dollars, and the amount recovered, if any, shall be administered as other personal property of the deceased person." General Laws of Oregon, ch 4, 367, p 941 (Civ Code) (Deady 1845-1864).

127 Or App 534> There is more evidence that bears on the state of the law before section 3 was adopted. In *Deane v. Willamette Bridge Co.*, 22 Or 167, 29 P 440 (1892), the Supreme Court recognized the constitutional authority of the legislature to govern the procedure of awarding damages when it upheld the constitutionality of a statute that required the court without the intervention of a jury to assess damages when the defendant was in default. The court noted the common law power of courts to decide questions of law and distinguished those matters from questions of fact to be decided by a jury under section 17. 22 Or at 173. It then held that the assessment of damages by a jury at common law when the defendant was in default was not a matter of right, but could be decided by the court alone. Thus, the statue was held constitutional in the face of a challenge under section 17.

Presumably, the drafters of section 3 were aware of existing statutes and precedents when section 3 was enacted in 1910. It is uncontroverted that the "mischief" at which the constitutional provision was aimed was the multiplicity of new trials that were being granted by trial courts on the basis of excessive damages. *Van Lom v. Schneiderman, supra,* 187 Or at 100. To remedy that problem, section 3 provides that a new trial cannot be ordered unless it can be said affirmatively that there is no evidence to support the verdict or that there was legal error committed during the initial trial. However, the authority of a trial court to grant a nonsuit or directed verdict on a point of law clearly remains unimpaired by the amendment. Lusk, "Forty Five Years of Article VII, section 3, Constitution of Oregon," 35 Or L Rev 1, 4, (1955).

In 1907, the legislature passed a law which amended the limitations on wrongful death damages and increased it to $7,500. *See* Lord's Oregon Laws 380. There is no evidence that I can find that suggests that the drafters of section 3 intended to nullify that law and it continued in various forms until 1967. Or Laws 1967, ch 544, 2. *See also Wiebe v. Seely, Administrator,* 215 Or 331, 351, 335 P2d 379 (1959).[2] Consequently, the authority of trial courts to set aside verdicts after **<127 Or App 534/535>** 1910 for excessive damages was limited, but the legislature's authority to limit the amount of reasonable damages remained unfettered. Under the circumstances, the majority cannot reasonably hold that the drafters intended by section 3 to abrogate the authority of the legislature to enact a statute like ORS 18.560.

In summary, the majority forgets about the import of the presumption that ORS 18.560 is constitutional, relies on a decision by the Washington Supreme Court about an unrelated provision of the Washington Constitution as the basis of its rationale, says that it cannot "discern" what "reexamination" of a fact means in the context of the plain language of section 3, and ignores the historical evidence about the objective of the framers of section 3. A philosophical difference with the legislature about the wisdom of the tort reform law is not a sufficient justification for declaring a statute unconstitutional. It is only when a statute violates the constitution expressly or implicitly that it is unconstitutional. ORS 18.560 does neither.

Because my analysis would result in holding that ORS 18.560 does not violate Article I, section 17, or Article VII (amended), section 3, I address plaintiff's alternative argument that the statute violates Article I, section 10, of the Oregon Constitution. Section 10 provides:

> "No court shall be secret, but justice shall be administered, openly and without purchase, completely and without delay, and every man shall have remedy by due course of law for injury done him in his person, property, or reputation."

Plaintiff argues that "the statute prevents a plaintiff with noneconomic damages in excess of $500,000 from receiving the 'remedy [* * *] for injury done him' which the constitution contemplates."

At common law, litigants had the right to recover damages for injury to their person or property and to have a jury assess those damages when the facts were in dispute. *Deane v. Willamette Bridge Co., supra,* 22 Or at 173. However, the right did not prevent the legislature from changing **<127 Or App 535/536>** common law remedies, or "attach[ing] conditions precedent to [their] exercise, and perhaps abolish[ing] old and substitut[ing] new remedies." *Mattson v. Astoria,* 39 Or 577, 580, 65 P 1066 (1901).[3]

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[2] In *Wiebe v. Seely, Administrator, supra,* what the court said about the nature of a statutory limitation on damages is instructive:

> "*[T]he statute does not deal with the function of the jury at all, but with that of the court.* The legislature has said, in effect, that regardless of the extent of the damages actually suffered by the plaintiff in an action against the estate of a deceased tort-feasor, *recoverable* damages may not exceed $15,000. * * * It is not suggested that such a statute is beyond the powers of the legislature." 215 Or at 352. (Emphasis supplied.)

[3] The Supreme Court has acknowledged the authority of the legislature to limit remedies for common law causes of action on a number of occasions. For example, in *Holden v. Pioneer Broadcasting Co. et al,* 228 Or 405, 365 P2d 845 (1961), *cert den* 370 US 157 (1967), the court held that statutes eliminating the right of a defamed person to receive damages for an inadvertent libel when a retraction was made were constitutional under Article I, sections 8, 10 and 20, of the Oregon Constitution. *See also Noonan v. City of Portland,* 161 Or 213, 248, 88 P2d 808 (1939); *Evanhoff v. State Industrial Acc. Com.,* 78 Or 503, 154 P 106 (1915).

Article XVIII, section 7, provides:

> "All laws in force in the territory of Oregon when this constitution takes effect, and consistent therewith, shall continue in force *until altered or repealed.*" (Emphasis supplied.)

Based on section 7, the Supreme Court in *Perozzi v. Ganiere*, 149 Or 330, 40 P2d 1009 (1935), rejected the plaintiff's contention that the legislature could not abolish or limit an automobile guest's remedy for negligent injury in an action brought against his host. The court said:

> "The right to alter all laws in force in the territory of Oregon when the constitution was adopted, whether the same were of common-law or legislative origin, was reserved to the people of the state by article XVIII, 7, supra. Indeed, that section of our organic act which adopted the common law of England clearly contemplated future changes in the common law, as evidenced in the condition expressed that the common law should continue in force '*until altered or repealed*'. Moreover, had it been the intention of the framers of the constitution to adopt and preserve the remedy for all injuries to person or property which the common law afforded, they undoubtedly would have signified that intention by exact and specific wording, rather than the language used in article I, 10." 149 Or at 346. (Emphasis in original.)

As the Supreme Court said in *Davidson v. Rogers*, 281 Or 219, 222, 574 P2d 624 (1978):

> "The language of the constitution does not specify that the remedy need be the same as was available at common law at the time of the adoption of the constitution; and the statute, *while restricting the remedy, does not abolish the cause of action.* Even though a retraction is not requested, the right of action still exists for an intentional defamation and, in any **<127 Or App 536/537>** event, for recovery of specific demonstrable economic loss. Such limitation is not violative of Art. I, 10, for the reason that it does not wholly deny the injured party a remedy for the wrong suffered." (Citations omitted; emphasis supplied.)

ORS 18.560 does not "wholly" deny plaintiff a remedy for his injury; it merely limits his recovery to all proven economic damages and up to $500,000 in noneconomic damages. Therefore, I would hold that ORS 18.560 is constitutional under section 10.

The call for judicial restraint in these kinds of matters was best expressed in 1882: "When there is nothing in the section of the constitution referred to inhibiting, expressly or impliedly, the power of the legislature to enact the law in question, * * * it is not therefore repugnant to that section." *Cresap v. Gray*, 10 Or 345, 349 (1882). Article VII (amended), section 3, Article I, section 17, and Article I, section 10, do not expressly or impliedly inhibit the legislature from setting statutory limitations on the amount of damages for which judgment can be lawfully entered. We should uphold the constitutionality of ORS 18.560 against plaintiff's attacks.

Richardson, C.J., and Deits and Landau, JJ., join in this concurring in part and dissenting in part opinion.

Cite as 127 Or App 700 (1994) May 4, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Mark C. Wells, Claimant.

SPERRY, INC., Petitioner,
v.
MARK C. **WELLS**, Respondent.
(92-00547; CA A80168)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 18, 1994.
Craig A. Staples argued the cause for petitioner. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.
James L. Edmunson argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
EDMONDS, J.
Affirmed.

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127 Or App 702> Employer seeks review of an order of the Workers' Compensation Board, assigning error to its ruling that a stipulation entered into by employer and claimant constitutes an acceptance of claimant's "achalasia" condition.[1] We review the Board's findings for substantial evidence, ORS 183.482(8)(c), and affirm.

Claimant suffered a compensable back injury in 1986. In 1987, while still receiving treatment for that injury, he experienced abdominal symptoms, consisting of heartburn, nausea, abdominal pain and difficulty swallowing food. As a result, he contacted a physician for treatment. The physician's treatment note, which was sent to employer, refers to treatment for "reflux esophagitis & ? esophageal/gastric hang-up."

Claimant filed a claim for the treatment, which was denied by the employer. The denial said:

> "We have recently received billings and chart notes indicating you were treated for reflux esophagitis & esophageal/gastric hang-up. This condition is not related to your back injury of February 25, 1986. Accordingly, we must notify you that we will be unable to accept these conditions as part of the claim established. Please note that this is only a partial denial and not a denial of the claim already established."

Following the denial, claimant's physician informed employer that claimant's "classic reflux esophagitis-type symptom" was related to the back injury. Claimant requested a hearing on the denial, but before the hearing he and employer entered into a "stipulation and order." As part of the stipulation, employer agreed to rescind its denial "of claimant's reflex esophagitis *and* esophageal gastric hang-up," and pay claimant compensation of $300. (Emphasis supplied.) Claimant agreed to dismiss his request for hearing with prejudice. The stipulation was approved by a Workers' Compensation Board referee.

127 Or App 703> During 1991, claimant continued to experience abdominal symptoms with increased severity. The condition was ultimately diagnosed as achalasia. After being informed of claimant's most recent treatment and the new diagnosis, employer denied compensability of that condition, and claimant requested a hearing. The referee found that the stipulation constituted an acceptance of a condition different from the achalasia condition and upheld employer's denial. On review, the Board found that the stipulation constituted an acceptance of the achalasia condition, because it was an acceptance of the symptoms of that condition. It reasoned that, by accepting a claim for the symptoms of achalasia, employer had accepted the underlying condition. *See Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988).

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[1] The record indicates that achalasia is a neurogenic disorder that interferes with the relaxation of the esophageal sphincter and thereby prevents the contents of the esophagus from entering the stomach. It stems from the denervation of the esophageal muscle, which ultimately impairs relaxation of the lower esophageal sphincter.

On review to this court, employer "accepts the referee's findings," which were adopted by the Board, but argues that its stipulation was not an "acceptance" and, if an "acceptance," the acceptance was limited to a condition other than achalasia. In support of its argument that its stipulation does not constitute an acceptance, employer relies on *Fimbres v. Gibbons Supply Co.*, 122 Or App 467, 857 P2d 904 (1993). In that case, the issue was whether the employer could deny a condition pursuant to ORS 656.262(6) that it had earlier stipulated was compensable. If the stipulation had been considered "an acceptance" in the technical sense, the employer would have been permitted, under ORS 656.262(6) to later deny the claim when it obtained evidence that the claim was not compensable. We held that the stipulation was not an "acceptance" that could later be rescinded pursuant to ORS 656.262(6), but a "negotiated, signed meeting of the minds based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party," that had the "finality and effect of a judgment." 122 Or App at 471.

The holding in *Fimbres* is not dispositive, because what is intended by a stipulation that results in the dismissal of a request for hearing is preliminarily a question of fact, specific to each case. *See International Paper Co. v. Pearson*, 106 Or App 121, 806 P2d 189 (1991). Here, employer does not contest the referee's findings, adopted by the Board, which include the finding that the stipulation constituted an "acceptance." Moreover, unlike in *Fimbres*, the issue here is not **<127 Or App 703/704>** whether there has been an "acceptance" in the technical sense, but whether employer's stipulation as to compensability encompasses claimant's subsequently diagnosed condition. The stipulation sets out claimant's diagnosis and rescinds the earlier denial of claimant's claim based on that diagnosis. That language constitutes substantial evidence that employer intended to agree to the compensability of claimant's condition.

Next, employer argues that it limited its acceptance to "reflux esophagitis & esophageal/gastric hang-up" and that claimant's specific condition of achalasia was never accepted. ORS 656.262(6) places the burden on the employer to specify what conditions are being accepted. The parties do not dispute that "achalasia" and "reflux esophagitis" are discrete infirmities. Although the treating physician's diagnosis of reflux esophagitis was tentative, that fact did not prevent employer from limiting its acceptance to a particular condition. *See Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987). However, employer's stipulation also refers to the "esophageal/gastric hang-up." The Board found persuasive the fact that employer rescinded its denial and entered into the stipulation after receiving a letter from claimant's physician that described claimant's condition as a "symptom." The Board said:

> "[W]e * * * find that the claim was *for symptoms*.
>
> "We find no evidence that claimant has more than one condition causing his ongoing abdominal and esophageal symptoms." (Emphasis in original.)

Employer's rescission of its denial of compensability encompassed both the reflux esophagitis condition and the esophageal/gastric hang-up symptom. In the light of the physician's letter and the language of the stipulation, there is substantial evidence that supports the Board's finding that employer accepted the symptoms of achalasia and, therefore, the condition itself.

Affirmed.

Cite as 127 Or App 735 (1994) May 4, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Carole A. VanLanen, Claimant.

SAIF CORPORATION and BELOZER FARMS, Petitioners,
v.
CAROLE A. **VANLANEN**, Respondent.
(92-02682; CA A79016)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 22, 1993.
Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Steven T. Fagenstrom argued the cause for respondent. With him on the brief was Galton, Scott & Colett.
Before Deits, Presiding Judge, and Riggs, Judge, and Durham, Judge pro tempore.
DURHAM, J. pro tempore.
Reversed as to assessment of penalty.

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127 Or App 737> SAIF seeks review of a Workers' Compensation Board order holding that SAIF failed to timely pay temporary total disability (TTD) benefits to claimant and assessing a penalty. We reverse.

SAIF denied the compensability of claimant's back injury. The referee found that the claim was compensable, and SAIF sought review. While the request for review was pending before the Board, a determination order awarded claimant TTD from the date of her injury until the date she was released to return to work. SAIF did not seek review of the determination order.[1] The Board issued an order affirming the referee's compensability order. SAIF began paying the "retroactive" TTD 35 days after the Board order. The Board concluded that those payments were not timely, because "it was incumbent upon SAIF to promptly pay claimant the ordered temporary disability benefits once the appeal period had passed" regarding the Board's compensability order.

SAIF argues that its payments were timely under OAR 436-60-150(4)(f), which provides, in part:

> "(4) Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:
>
> "* * * * *
>
> "(f) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order shall begin no later than the 14th day after the date the order is issued."

ORS 656.295(8) provides, in part:

> "An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298."

127 Or App 738> SAIF argues that the Board's compensability order was "litigation authorizing retroactive temporary disability," within the meaning of the rule, and that it became final 30 days after it was issued, when the statutory right to appeal expired.

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[1] In *SAIF v. VanLanen*, 120 Or App 613, 852 P2d 281 (1993), *on recon* 127 Or App 346 (1994), we held that, under ORS 656.313, SAIF's request for Board review regarding compensability entitled it to stay payment of TTD that accrued from the date of claim denial until the referee's compensability order became final, and that SAIF's failure to request reconsideration or review of the determination order did not affect the stay.

Claimant argues that the compensability dispute was not litigation authorizing retroactive disability, because the compensability order "did not authorize payment of TTD. The sole issue before the Workers' Compensation Board was compensability." (Emphasis in original.)

We agree with SAIF. Because claimant's right to receive the retroactive disability depended on a finding of compensability, the dispute over compensability was "litigation authorizing retroactive temporary disability" under the rule.

Claimant also argues that the Board's order was "final" when issued, not 30 days later when the right to appeal expired. ORS 656.295(8) lends some support to that argument, because it declares that the Board order "is final unless within 30 days" a party appeals. However, that statute controls whether a Board order is final, not when retroactive temporary disability litigation becomes final. SAIF correctly argues that "[t]he statute allows SAIF 30 days to decide whether it will appeal the Board's order." We conclude that, under OAR 436-60-150(4)(f), the date when "litigation authorizing temporary disability becomes final" is the date on which the parties' right, under ORS 656.298(1), to appeal a Board order expires. Claimant's reading would create the anomalous result that the insurer would be obligated to pay TTD before expiration of the period within which it is entitled to decide whether to appeal the compensability order. Because SAIF paid the retroactive TTD within the 14 days permitted by the rule, the Board erred in concluding that the payment was untimely.

Reversed as to assessment of penalty.

Cite as 127 Or App 739 (1994) May 4, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald Martin, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
DONALD **MARTIN**, Respondent.
(92-10346; CA A80804)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 13, 1994.
Adam T. Stamper argued the cause for petitioner. On the brief were Peter L. Deuel and Cowling & Heysell.
Pamela A. Schultz argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Board's order that employer reprocess claim vacated; otherwise affirmed.

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127 Or App 740> Employer seeks review of an order of the Workers' Compensation Board that ordered it to reprocess claimant's claim to initial closure. We agree with employer that it had already properly processed the claim to closure by its notice of closure dated March 28, 1991. All issues between the parties were addressed and no further processing is required.

Board's order that employer reprocess the claim vacated; otherwise affirmed.

May 18, 1994 Cite as 128 Or App 53 (1994)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daniel P. Kelsey, Claimant, and In the Matter of the Complying Status of Drushella-Klohk NCE.

DANIEL P. **KELSEY**, Petitioner,
and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Intervenor,
v.
DRUSHELLA-KLOHK NCE and SAIF CORPORATION, Respondents.
(Agency Nos. 91-10681 and 91-14721; CA A79650)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 15, 1994.
Darrell E. Bewley argued the cause for petitioner. With him on the brief was Estell and Bewley.
Ridgway K. Foley, Jr., argued the cause for respondent Drushella-Klohk NCE. With him on the brief were Richard T. Kropp, Foley & Duncan, P.C., and Emmons, Kropp, Kryger, Alexander, Egan & Allen, P.C.
Stephanie L. Striffler, Assistant Attorney General, argued the cause for intervenor Department of Consumer and Business Services. With her on the briefs were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Michael O. Whitty, Special Assistant Attorney General, waived appearance for respondent SAIF Corporation.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Remanded to Board with instructions to dismiss appeal to Board.

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128 Or App 56> Claimant seeks review of an order of the Workers' Compensation Board in this consolidated proceeding to determine whether Duane Drushella and Joan Klohk-Drushella (respondents) are noncomplying employers and whether claimant's claim is compensable. ORS 656.740(4).

Claimant was injured when he fell from the roof of a house that he was remodeling for respondents, who had purchased the house as a vacation home. Although respondents had never lived in the house at the time claimant was injured, they had rented it to a third party on one occasion, in payment for that party's cabinetry work.

After the accident, claimant filed a claim. The Department of Insurance and Finance (DIF)[1] investigated the matter and concluded that respondents, who had no workers' compensation coverage for claimant, were noncomplying. Respondents denied claimant's claim. SAIF, acting as the processing agent for DIF, accepted the claim. Respondents filed a request for hearing on DIF's order and also filed a separate request for hearing on SAIF's acceptance of the claim. The matters were consolidated for hearing pursuant to ORS 656.740(4).

The referee held that respondents were not noncomplying, because claimant was injured while remodeling a private home belonging to respondents, and such employment is specifically excluded from workers' compensation coverage by ORS 656.027(2). The referee set aside DIF's order of noncompliance as well as SAIF's acceptance of the claim.

An order of a referee regarding the compliance of a putative employer is deemed to be the final order of DIF. ORS 656.740(4)(a). Ordinarily, that order is subject to review pursuant to the Administrative Procedures Act (APA). ORS 656.740(4). Judicial review of the referee's order would be by the Court of Appeals. ORS 183.482. If, however, the order **<128 Or App 56/57>** declaring the

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[1] DIF has been replaced by the Department of Consumer and Business Services (DCBS). DCBS filed an intervenor's brief in the Court of Appeals, on behalf of claimant. However, on the question of service, DCBS agrees with respondents that it was not properly served and that the Board lacked jurisdiction to consider claimant's appeal. SAIF has waived appearance.

person to be noncomplying is contested at the same hearing as a matter concerning a claim, then review of the order of noncompliance is as a matter concerning a claim, ORS 656.740(4)(c), and is subject to review by the Board. Thus, because respondents' requests for hearing raised questions concerning the compensability of the claim, as well as questions of compliance, the matter was subject to review by the Board. On claimant's appeal to the Board, the Board affirmed the referee.

Claimant seeks review, contending that the Board erred in concluding that his work was excluded from workers' compensation coverage under ORS 656.027(2), because the house was not respondents' private home, but a commercial investment. We need not address the merits of the petition, because we conclude that the Board lacked jurisdiction to consider claimant's appeal.

DIF took an active role at the hearing, in order to defend its decision that respondents were noncomplying employers. The referee mailed a copy of the final order to DIF. Claimant never served DIF, or anyone on DIF's behalf, with a copy of his notice of appeal to the Board. DIF filed a motion to dismiss the appeal, which the Board denied. That was error. ORS 656.295(2) requires that a request for Board review of a referee order

> "be mailed to the board and copies of the request * * * be mailed to all parties to the proceeding before the referee."

The request must be served on all parties within 30 days after the date on which the referee's order is mailed. *See* ORS 656.289(3). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237, 831 P2d 721 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 51, 706 P2d 178 (1985); *Argonaut Insurance v. King*, 63 Or App 847, 666 P2d 865 (1983). All parties to the referee's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. *Mosley v. Sacred Heart Hospital, supra*, 113 Or App at 237. Thus, although claimant does not directly contest that aspect of the referee's **<128 Or App 57/58>** order regarding noncompliance, DIF was required to be served or receive actual notice of the appeal within the 30-day period, if it is a party entitled to service.

The Board relied on the definition of "party" contained in ORS 656.005(20) to conclude that DIF is not a party entitled to service. That statute provides:

> "'Party' means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer."

The Board reasoned that, because that definition does not mention DIF, DIF is not a party and need not be served with a request for review. The definition contained in ORS 656.005(20) is a general definition intended to apply to the procedures under ORS Chapter 656, including Board adjudications of matters concerning a claim. Its definition of "party" does not apply "where the context otherwise requires." ORS 656.003. We conclude that, when the Board's adjudication is to include review of an order of DIF regarding noncompliance, context requires otherwise, and DIF must be treated as a party entitled to be served with notice under ORS 656.295(2). Although DIF appeared before the Board, it was not served with notice of the appeal and there is no indication in this record that it had actual notice of the appeal within the statutory period. *See Argonaut Insurance v. King, supra; Zurich Ins. Co. v. Diversified Risk Management, supra.*

There is another reason why we conclude that DIF was entitled to be served with a copy of the request for Board review. As we have noted, the referee's order is deemed to be DIF's order. ORS 656.740(4)(a). Had the referee's compliance determination been the only issue, review would have been directly by the Court of Appeals pursuant to the APA. In that circumstance, the petition would have to have been served "upon the agency, and all other parties of record in the agency proceeding." ORS 183.482(2). That would have included DIF. We see no basis for treating DIF differently because the compliance matter has been consolidated for hearing and review with a matter concerning a claim.

Remanded to Board with instructions to dismiss appeal to Board.

May 25, 1994 Cite as 128 Or App 71 (1994)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Wayne Bennett, Claimant.

WAYNE **BENNETT**, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and SILTEC CORPORATION, Respondents.
(91-11454; CA A80711)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 2, 1994.
Margaret H. Leek Leiberan argued the cause for petitioner. With her on the brief were Leiberan & Grazeley and Richard M. Walsh.
Patricia Nielsen argued the cause for respondents. With her on the brief was Kevin L. Mannix, P.C.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Reversed and remanded for reconsideration.
Edmonds, J., dissenting.

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128 Or App 73> Claimant seeks review of an order of the Workers' Compensation Board that affirmed employer Siltec Corporation's (Siltec) denial of his claim for compensation for hearing loss. We reverse.

Claimant worked for Caterpillar, Inc. (Caterpillar) and its predecessor beginning in 1964. At that job, he was exposed to noisy conditions. Sometime after Caterpillar purchased the company in the early 1970's, claimant began wearing hearing protection. He also began to notice a hearing loss. When claimant left employment with Caterpillar in April, 1989, he had suffered significant bilateral hearing loss. He did not seek treatment or file a worker's compensation claim.

Claimant did not work again until January, 1990, when he began to work in the edge grinder department at Siltec. That job also exposes claimant to noise; he wears hearing protection, although there is a dispute about how much he wears the protection and whether it was properly fitted.

In 1991, claimant filed claims for hearing loss against Caterpillar and Siltec. Caterpillar denied the claim on the basis that claimant's condition did not arise out of or in the course of his employment with Caterpillar and that the claim was not timely filed. Siltec originally denied only responsibility, asserting that the hearing loss was a result of claimant's exposure to noise at Caterpillar, and that work conditions at Siltec did not contribute to the hearing loss.

Claimant entered into a disputed claim settlement (DCS) with Caterpillar. In that agreement, the parties stipulated, in part:

> "[Caterpillar] denied this claim on March 12, 1991, for the reason that claimant's condition did not arise out of or in the course and scope of his employment, and further, that he has untimely filed the claim. There being a bona fide dispute and the parties wishing to resolve this matter on a disputed claim basis, and both having evidence to respect [sic] their respective positions;
>
> "IT IS HEREBY STIPULATED AND AGREED that this matter be compromised and settled, * * * by [Caterpillar's **<128 Or App 73/74>** insurer] paying and claimant accepting, the sum of $7,500 in full and final settlement of his claim. In consideration for this payment, claimant agrees that his claim shall remain in its denied status and that he shall take no workers' compensation benefits on account thereof."

The denial by Siltec went to hearing. At the outset of the hearing, Siltec asserted that it denied both compensability and responsibility. Claimant did not object to the addition of compensability as an issue.

The referee upheld Siltec's denial. The Board affirmed and adopted the referee's order. It relied on *Garcia v. Boise Cascade Corp.*, 103 Or App 508, 798 P2d 265 (1990), to hold that, because Siltec was the only potentially responsible employer left in the case after claimant entered into the DCS with Caterpillar, claimant had elected to prove actual causation against Siltec and could not rely on the last injurious exposure rule to establish the compensability of his claim. It distinguished *E.C.D., Inc. v. Snider*, 105 Or App 416, 805 P2d 147 (1991), and *Meyer v. SAIF*, 71 Or App 371, 692 P2d 656 (1984), *rev den* 299 Or 203 (1985), on the ground that those cases, which allowed application of the last injurious exposure rule when only one employer remained in the case, involved responsibility issues only.

In order to establish that his hearing loss is an occupational disease, claimant must show that it arose "out of and in the course of employment" and was "caused by substances or activities to which [he was] not ordinarily subjected or exposed other than during a period of regular actual employment * * *." ORS 656.802(1). He must show that work was the major contributing cause of his disease. *See Runft v. SAIF*, 303 Or 493, 498, 739 P2d 12 (1987). When a claimant asserts that work conditions at a single employer are the cause of a disease, the proof requirements are relatively straight forward: The claimant must show that employment conditions at that employer were the major contributing cause of the disease. When a claimant asserts that work conditions at multiple employers contributed to the disease, the claimant faces difficulties in proving a work relationship: "[T]he claimant must show not only that the disease's major contributing cause was work related, but also show which **<128 Or App 74/75>** employer is responsible for payment of compensation." 303 Or at 499.

The courts have adopted the last injurious exposure rule to mitigate that difficulty. The rule is that,

> "if a workers' compensation claimant has worked for more than one employer that could have contributed to the claimant's occupational disease, the last injurious exposure rule assigns full responsibility for payment of compensation for the disease to the last [employer that could have contributed to the disease] for whom the claimant worked." 303 Or at 499. (Footnote omitted.)

The rule is used both as a rule of proof, to relieve claimants of the need to prove the degree to which exposure to disease-causing substances or conditions at a particular employment caused the disease, and as a means of assigning responsibility as a matter of administrative efficiency. It operates generally for the benefit of the interests of claimants, relieving them of the sometimes impossible task of proving which of multiple employers actually caused a work-related condition. *See Bracke v. Baza'r*, 293 Or 239, 249, 646 P2d 1330 (1982).[1]

Claimant argues that he did not elect to prove actual causation by Siltec by entering into the DCS with Caterpillar, and that he should be able to rely on the last injurious exposure rule to prove that employment caused his condition. Siltec argues that the rule cannot be used in this case, because claimant did elect to prove actual causation by settling his claim against Caterpillar. The effect of the DCS, according to Siltec, is to make any hearing loss that was caused by claimant's employment at Caterpillar a preexisting noncompensable condition. Accordingly, claimant must show that **<128 Or App 75/76>** employment at Siltec was the major contributing cause of a worsening of the preexisting noncompensable disease.[2]

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[1] The dissent says that the 1990 enactment of ORS 656.308(1) "effectively overturned the last injurious exposure rule as it relates to industrial injuries," citing *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993). 128 Or App at 82 n 2. We disagree that ORS 656.308(1) has any effect on the last injurious exposure rule in an initial claim context. Both ORS 656.308(1) and *SAIF v. Drews, supra*, address the shifting of responsibility from an employer that is responsible for an accepted claim, to a later employer that has made some contribution to the disability or need for treatment of the same condition. The statute has no application in this case, because there is no accepted claim. In this initial claim context, the question is whether claimant has a compensable claim at all and, if so, whether Siltec is the responsible employer.

[2] The dissent takes a different tack, concluding that the reason for applying the last injurious exposure rule does not exist in this case, because claimant attributed a portion of his hearing loss to his employment with Caterpillar. 128 Or App at 80. The DCS, in fact, does not result in a finding of either compensability or responsibility as against Caterpillar; instead, it says that claimant's claim "shall remain in its denied status." That is not a recognition that Caterpillar caused claimant's hearing loss. Further, as we said in *Medford Corp. v. SAIF*, 128 Or App 119, ___ P2d ___ (1994), Oregon law does not provide for apportioning liability among several employers for a single condition.

In *Garcia v. Boise Cascade Corp., supra,* the claimant sought to apply the last injurious exposure rule to hold his last employer liable for his degenerative back condition. After concluding that substantial evidence supported the Board's finding that employment was not the major contributing cause of the claimant's condition, we addressed the last injurious exposure argument and said:

> "Under [the last injurious exposure] rule, the last employer whose work could have caused the condition is responsible without proof of actual causation. That rule has no application here, because only one self-insured employer is involved. By bringing a claim against employer only, claimant elected to prove actual causation." 103 Or App at 511. (Citations omitted.)

Because we had already upheld the Board's finding that the claimant's condition was not caused in major part by the claimant's employment, our discussion of the last injurious exposure rule was *dictum.* The threshold question whenever compensability is at issue is whether employment was the major contributing cause of the condition. Because the claimant in *Garcia* had not proved that, his argument that the last injurious exposure rule should have applied was moot: Without the requisite employment connection, there is no compensable claim. Our discussion of the last injurious exposure rule in *Garcia* was not necessary to our decision in that case, and we decline to follow it.[3]

In *Meyer v. SAIF, supra,* and *E.C.D., Inc. v. Snider, supra,* we held that each of the claimants could rely on the last injurious exposure rule to obtain compensation for their **<128 Or App 76/77>** claims against a single employer. Siltec attempts to distinguish those cases on the basis that they involved issues of responsibility only and that, here, compensability was also an issue.

In *Meyer,* there was no dispute that the claimant's asbestosis was caused by his employment. SAIF nonetheless argued that the disease was not compensable, because it had been caused by earlier extensive exposures to asbestos, and the claimant's exposure while working for SAIF's insured was too brief and too recent to have caused the disease. It argued that the asbestosis was a preexisting condition and therefore the claimant had to meet the standard for proving compensability of a worsening of a preexisting condition. In response to SAIF's argument that the last injurious exposure rule did not apply, because only one potentially responsible employer was in the case, we said that

> "[t]he rule applies when the occupational disease could have been caused by work conditions at any one of several employments, and the question is which employer is responsible. * * * Simply because SAIF is the only insurer that is a party to this case does not render the rule inapplicable." 71 Or App at 373 n 1. (Citations omitted.)

We then applied the rule and concluded that, because the employer insured by SAIF could have caused the claimant's asbestosis, "that employment is deemed to have caused the disease." 71 Or App at 375.

In *E.C.D., Inc. v. Snider, supra,* in which responsibility was the only issue, we again said that a later insurer could contest responsibility, even though it was the only potentially responsible insurer left in the case.

The holdings of those two cases do not compel any particular conclusion about whether the last injurious exposure rule can apply as against a single employer when compensability is an issue. Siltec has not articulated a persuasive argument for allowing application of the rule for assignment of responsibility but not as a rule of proof of causation, when only one potentially causal employer remains in the case.[4] **<128 Or App 77/78>** The two applications of the last injurious exposure rule are identical; they merely serve two different purposes, one to make assignment of responsibility more administratively efficient and the other to assist a claimant's proof of compensability. The different purposes provide no basis for denying application of the rule in one situation but allowing its use in another.

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[3] The dissent faults us for not following the principle of *stare decisis.* We decline to apply that principle to the *dictum* in *Garcia.*

[4] Siltec argues that allowing claimant to rely on the last injurious exposure rule under these circumstances would be unfair to employer and would be against public policy. It does not provide any explanation for or expansion on the argument. There is no obvious unfairness from application of the rule, nor do we see how it would run counter to public policy.

As the court said in *Bracke v. Baza'r, supra,* a claimant can elect to prove actual causation against a single employer. That is not this case. Claimant filed claims against both employers; his claim has consistently been that both employers could have contributed to his hearing loss. The DCS does not, by its terms, evidence an agreement by claimant that work at Caterpillar did not contribute in any way to claimant's loss of hearing; nor does it by its terms indicate an election to prove actual causation as against Siltec. There is nothing in the DCS with Caterpillar that shows an election to prove actual causation against Siltec.

Accordingly, claimant must show that employment conditions, which may include conditions to which he was exposed at Caterpillar, were the major contributing cause of his hearing loss. If he does that, he may rely on the last injurious exposure rule to prove the compensability of the claim against Siltec by showing that employment conditions there could have caused the condition. As we said in *E.C.D., Inc. v. Snider, supra,* if the evidence shows that employment at Siltec could not have caused claimant's condition, the result is that claimant will receive no compensation. That is a consequence that claimant must be deemed to have accepted by entering into the DCS with the only other potentially causal employer.

Claimant also assigns error to various findings by the Board. Because, on reconsideration, the Board may make whatever findings are necessary to application of the correct legal test, we will not address claimant's assignments that challenge the findings.

Reversed and remanded for reconsideration.

128 Or 79> **EDMONDS, J., dissenting.**

The Workers' Compensation Board found that claimant's employment with Siltec, his last employer, was not the major contributing cause of his hearing disability or any worsening of it. Consequently, it held that claimant had failed to establish the compensability of his condition as to Siltec.[1] The majority reverses, holding:

> "Accordingly, claimant must show that employment conditions, which may include conditions to which he was exposed at Caterpillar, were the major contributing cause of his hearing loss. If he does that, he may rely on the last injurious exposure rule to prove the compensability of the claim against Siltec by showing that employment conditions there could have caused the condition." 128 Or App at 78.

Claimant worked for Caterpillar and its predecessor from 1964 to 1989. He suffered a significant loss of hearing during that period of time. He began to work for Siltec in January, 1990, and filed his claims against Caterpillar and Siltec in October of that year. One expert testified that the audiology reports indicated that "there was almost no decrease in [claimant's] hearing acuity while he worked [for Siltec], and that the major extent of his hearing loss occurred while he was at [Caterpillar]." He said that "maybe 5 percent" of the loss could be attributed to Siltec. Another witness opined that if claimant had worn his ear plugs while working at Siltec as he had told the witness he had, the change in claimant's hearing after he began work at Siltec was not likely to have been caused by exposure to noise at Siltec, but could have been caused by the aging process. Both employers denied the claims. Claimant requested a hearing on both denials. Before the hearing, he entered into a disputed claims settlement with Caterpillar. The majority reverses the Board and holds that the last injurious exposure rule is applicable. I disagree.

128 Or App 80> The "last injurious exposure" rule is both a rule of proof and a rule of responsibility. It relieves a claimant of proving that exposure at a particular employer's work place caused the disease, because the claimant is required to prove only that the disease was caused by an employment-related exposure. It also assigns responsibility to the last employer at which claimant could

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[1] The Board adopted the findings of the referee, who said:

"[N]either audiologist opined that the condition *actually* worsened during the Siltec employment. The evidence does not support a proposition that claimant's employment at Siltec was even a material contributing cause of any worsening of the condition, and certainly does not rise to the level of establishing that the Siltec employment was the major contributing cause." (Emphasis in original.)

have been exposed to the disease-causing substances. *Runft v. SAIF*, 303 Or 493, 500, 739 P2d 12 (1987). The purpose underlying both parts of the rule is to provide claimant a remedy when it is demonstrable that the condition is work-related, but the trier of fact is unconvinced that any one employment is the likeliest cause of the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 245, 675 P2d 1044 (1984).

In *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), the court held that liability was properly assigned to the claimant's previous employer when the onset of the disease occurred at that employment and the subsequent employment did not contribute to the disease. It held that under the circumstances, the last injurious exposure rule was not applicable. It said: "There is no reason to apply the rule with any greater arbitrariness than is required to achieve its purposes * * *." 293 Or at 250 n 5. Here, as in *Bracke v. Baza'r, supra*, the finder of fact did not believe that the subsequent employment worsened claimant's hearing disability.

Moreover, although he was aware that one expert attributed at least 95% of his hearing loss to his employment at Caterpillar and the other did not believe his disability was caused by his employment at Siltec, claimant chose not to pursue his claim against Caterpillar in lieu of a settlement for $7,500. By the settlement, claimant attributed a portion of his hearing loss to his 25-year period of employment with Caterpillar. When it is uncontroverted that the disability is caused by an exposure occurring during an earlier employment, there is no reason to apply the last injurious exposure rule even if the work exposure at the later employment could have contributed to the disability. *See Boise Cascade Corp. v. Starbuck, supra*, 296 Or at 243. The rule "is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did **<128 Or App 80/81>** not." 296 Or at 244. Because the issues of compensability and responsibility are resolved as to Caterpillar, there is no policy reason to relieve claimant of the burden of demonstrating that the actual causation of his hearing loss was his employment at Siltec.

Our decision in *Garcia v. Boise Cascade Corp.*, 103 Or App 508, 798 P2d 265 (1990), was based on a similar analysis. In that case, the claimant had osteoarthritis in his lower back, a degenerative condition that was manifested after 1980. He had worked for the employer from 1963 to 1980, when he was laid off. He then worked for several employers until he was rehired by the employer in February, 1983. He was injured in 1985. The employer accepted the claimant's claim for injury except for the degenerative changes in his back, which it denied. On hearing, the Board held that the claimant had failed to prove that "the work activities for the employer were the major contributing cause" of his condition. The claimant argued that the last employer should be found liable under the last injurious exposure rule. Judge Warren, writing for this court, said that the last injurious exposure rule had no application when the claim was brought against one employer only, because by doing so, "claimant elected to prove actual causation." 103 Or App at 511. That reasoning is no less applicable here.

In summary, I would hold claimant to the legal effect of his settlement with Caterpillar. When he entered into a disputed claim settlement agreement, the need for the application of the last injurious exposure rule disappeared because the remaining claim is against only one employer. The threshold issue is whether claimant's condition was caused solely by the work activities at Siltec. The Board was right when it reasoned that the result in this case is controlled by our holding in *Garcia*. By his settlement, claimant has elected to proceed against only Siltec, and he should be held to the same standard of proof that would have existed had he initially filed his claim against only Siltec. After reading the majority opinion, the Board and employer will feel like they have been in a football game where every time a team gets ready to kick a field goal, the referee changes the locations of the goal posts. In an area of the law fraught with statutory interpretation **<128 Or App 81/82>** and hypertechnicalities, we do no service to claimants or employers when we fail to honor the principle of *stare decisis*.

I dissent.[2]

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[2] As part of the 1990 amendments to the Workers' Compensation Laws, the legislature enacted ORS 656.308, which effectively overturned the last injurious exposure rule as it relates to industrial injuries. *See SAIF v. Drews*, 318 Or 1, 7 n 3, 860 P2d 254 (1993). The legislature did not intend to overrule case law concerning the rule as it relates to occupational diseases. *See* Tape Recording, House Special Session, May 7, 1990, Tape 2, Side A at 190 (Representative Mannix) ("This bill does not address responsibility in occupational disease claims. That to me is a glaring omission that I hope we will take up next session."). *But see Liberty Northwest Ins. Corp. v. Senters*, 119 Or App 314, 850 P2d 403 (1993).

May 25, 1994 Cite as 128 Or App 119 (1994)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dean M. Hunsaker, Claimant.

MEDFORD CORPORATION, Petitioner,
v.
SAIF CORPORATION and DEAN M. HUNSAKER, Respondents.
(Agency nos. 92-03563 and 92-03562; CA A79649)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 28, 1994.
H. Scott Plouse argued the cause for petitioner. With him on the brief was Cowling & Heysell.
Steven Cotton, Assistant Attorney General, argued the cause for respondent SAIF. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
No appearance for respondent Hunsaker.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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128 Or App 121> Employer, Medford Corporation (Medco), a self-insured employer, seeks review of a Workers' Compensation Board order holding that Medco is responsible for claimant's work-related hearing loss. We affirm the Board.

Claimant suffered bilateral hearing loss while working for Medco between 1954 and 1991, during which time he was exposed to noise from chain saws and air compressors. Medco was insured by SAIF until July 1, 1988, at which time it became self-insured. Claimant has had several hearing tests over the years. The last test that he had before Medco became self-insured was on August 13, 1987; the test indicated a combined binaural hearing loss of 23.31 percent.

Claimant filed his claim on October 31, 1991. He sought treatment from Dr. Ediger on November 26, 1991, and a hearing test taken on that day indicated a combined binaural hearing loss of 28.18 percent. Both SAIF and Medco, in its self-insured capacity, denied the claim. The Board found that claimant first sought treatment for his condition after Medco became self-insured. It held that Medco, in its self-insured capacity, was responsible for the claim and that SAIF was not.

The parties concede that the claim is compensable, because claimant's work is the major contributing cause of his condition. They also concede that each period of employment contributed to claimant's hearing loss. The only question is which insurer, SAIF or Medco as self-insured, is responsible for the claim. The Board's finding that claimant first sought medical treatment for his condition in November, 1991, after Medco became self-insured, is supported by substantial evidence. Claimant has not experienced any time loss as a result of his condition. Under application of the last injurious exposure rule, responsibility for the entire condition is properly assigned to Medco, the party at risk at the time claimant first sought medical treatment. *Progress Quarries v. Vaandering*, 80 Or App 160, 722 P2d 19 (1986); *SAIF v. Carey*, 63 Or App 68, 662 P2d 781 (1983).

Medco argues that, because claimant's hearing loss from each period of employment can be precisely quantified, claimant has, in fact, two disabilities, responsibility for which **<128 Or App 121/122>** can be allocated to two separate entities. The argument has superficial appeal; however, it overlooks the fact that, although it is possible to measure the contribution that each period of employment made to claimant's hearing loss, claimant has but one hearing loss. Oregon law does not apportion liability among several employers or insurers for a single condition. Under Oregon's application of the last injurious exposure rule, full responsibility for the claim is assigned to Medco, based on the last period of employment that contributed to claimant's hearing loss. *Runft v. SAIF*, 303 Or 493, 739 P2d 12 (1987); *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ramon M. Marin, Claimant.

SAIF CORPORATION and OREGON GARDEN PRODUCTS, Petitioners,
v.
RAMON M. **MARIN**, Respondent.
(WCB No. 92-07796; CA A81240)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 21, 1994.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Bradley P. Avakian argued the cause for respondent. On the brief were Lynn-Marie Crider and James L. Francesconi.

Before Deits, Presiding Judge, and Riggs and Haselton, Judges.

DEITS, P.J.

Reversed and remanded for reconsideration.

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128 Or App 163> SAIF seeks review of an order of the Workers' Compensation Board that holds that claimant's injury was compensable. Claimant's injury occurred while he was attempting to jump start his car, which was in the employer's parking lot, after he had completed his work shift. The issue in the case was whether there was a sufficient work relationship between the injury and claimant's employment. The Board concluded that the fact that the injury occurred on the employer's parking lot while he was attempting to leave work established a sufficient work connection to prove compensability.

Since the time of the Board's decision in this case, the Supreme Court decided *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 867 P2d 1373 (1994). In that case, the court explained that in evaluating the work connection of an injury, both the "arising out of" and "in the course of" elements of the test must be considered; neither is dispositive. The court stated that the fact that an injury occurs on work premises, such as a parking lot satisfies only the "in the course of" aspect of the work connection. It remains necessary to evaluate the "arising out of" aspect of the injury by assessing the causal link between the claimant's employment and the injury. In this case, the Board considered only the "in the course of" element of the work-connection test. Accordingly, it is necessary to remand this case to the Board to allow it to consider whether the injury "arose out of" claimant's employment.

Reversed and remanded for reconsideration.

May 25, 1994 Cite as 128 Or App 181 (1994)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John H. Hensley, Claimant.

GEORGIA-PACIFIC CORPORATION, Petitioner,
v.
JOHN H. **HENSLEY**, Respondent.
(WCB 91-17455; CA A80868)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 24, 1994.
Jerry K. Brown argued the cause for petitioner. On the brief were Charles L. Lisle and Cummins, Brown, Goodman, Fish & Peterson.
Lynne W. McNutt filed the brief for respondent.
Before Deits, Presiding Judge, and Warren and Riggs, Judges.
RIGGS, J.
Affirmed.

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128 Or App 183> Employer seeks review of an order of the Workers' Compensation Board affirming the referee's award of permanent partial disability (PPD). We affirm.

Claimant filed a workers' compensation claim alleging a binaural hearing loss, and he was determined to be medically stationary on June 12, 1991. Claimant had audiograms done by a number of doctors, including ones by Dr. Ediger on February 19, 1991, showing a 6.25 per cent loss, Dr. Hiatt on June 12, 1991, showing a 10.25 percent loss, and Dr. Hurbis on September 16, 1991, showing a 23.25 percent loss. The claim was closed, and claimant received a scheduled award for a 10.25 percent loss of hearing in the left ear. On reconsideration, the closure was affirmed. Claimant requested a hearing, and the matter was submitted to the referee for decision on the documentary record. The referee granted a scheduled award of 23.25 percent, the Board affirmed and employer seeks review.

Employer argues that OAR 436-35-250 requires reversal. That rule provides, in part:

> "(3) Compensation for hearing loss shall be based on an audiogram performed within 6 months of the medically stationary date, which shows the highest levels of retained hearing."

Employer asserts that Ediger's exam shows "the highest levels of retained hearing" and, therefore, claimant should have been granted an award of only 6.25 percent. Employer would be correct if OAR 436-35-250(3) were the only provision governing the award of compensation. However, OAR 436-35-250(3) was promulgated under the authority of ORS 656.726(3)(f), which requires that any standards established by rule must also comply with the other provisions of ORS 656.726(3)(f). One of those is ORS 656.726(3)(f)(B), which provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." Reading the rule in conjunction with the statutory provision, the rule establishes a *prima facie* determination of what establishes "a preponderance of medical evidence" in a hearing loss case. However, the rule does not preempt the referee from performing the statutory duty to determine the level of **<128 Or App 183/184>** impairment by a preponderance of medical evidence. In this case, the referee found that claimant had suffered a 23.25 percent hearing loss. That finding is supported by the evidence. Accordingly, we affirm the Board's order.

Affirmed.

May 25, 1994 Cite as 128 Or App 204 (1994)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION, Petitioner,
v.
MARV'S UTILITY SPECIALISTS, Respondent.
(Agency No. SH-92060; CA A81198)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 15, 1994.
J. Dean Taylor, Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
David W. Hittle argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander, McCann & Smith.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
DE MUNIZ, J.
Reversed and remanded with instructions to reinstate citations 1-3 and 2-8.

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128 Or App 206> Petitioner Occupational Safety and Health Division (OSHD) seeks review of an order of the Workers' Compensation Board[1] holding that employer did not violate administrative rules adopted by the Director of the Department of Insurance and Finance (DIF) pursuant to the Oregon Safe Employment Act. We reverse.

On September 17, 1991, an OSHD enforcement officer inspected an excavation site where a pipe was being installed in a trench. The officer testified that the trench measured approximately 14 feet long, 5 feet wide and 12 feet deep, and that there was an eight-foot long shoring system.[2] He did not enter the trench to make those measurements; he used a measuring tape while standing at the top of the excavation.

The officer cited employer for various violations of worker safety rules, but only two of the citations are at issue here. Citation 1-3 alleged that employer violated 29 CFR 1926.652(e)(2)(i),[3] because there was more than two feet of unprotected soil extending below the bottom of the shoring system in the excavation trench. Citation 2-8 concerned the protective shoring system. On the basis of his conclusion that the soil in the area was Type C, the officer alleged that employer violated 29 CFR 1926.652 (a)(1), because it used an improper shoring system design and an insufficient number of vertical shores in the system.

Employer requested a hearing on the citations. Following the hearing, the referee dismissed both citations. The referee found that there was three feet of exposed soil **<128 Or App 206/207>** below the bottom of the support system.[4] However, the referee held that

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[1] The referee's order is considered a final order of the Worker's Compensation Board. ORS 654.290(2)(b).

[2] A shoring system is a structure that supports the sides of an excavation and is designed to prevent cave-ins.

[3] Chapter 437, Subdivision P, of the Oregon Administrative Rules contains the rules adopted by DIF, under the Oregon Safe Employment Act. The rules adopt by reference federal rules promulgated by the Secretary of Labor under the Construction Safety Act, 40 USC 333, and the Occupational Safety and Health Act of 1970, 29 USC 653, 655, and 657. We cite the Code of Federal Regulations, because the Oregon Administrative Rules adopt the federal numbering system.

[4] The referee stated:

> "I conclude that upon visual inspection of the photographs, the area of exposed soil below the bottom of the support system is 3 feet and not 4 feet." Although that statement is contained in the "Opinion and Conclusion" section of the referee's order, it can only be considered a finding of fact, and we treat it as such.

> "there being no evidence of possible loss of soil from beneath or below the bottom of the support system, I can only conclude that the excavation in excess of 2 feet is not in violation of the rule."

In addition, the referee held that citation 2-8 was not a violation, because the use of two cylinders in the shoring system "was adequate given an 8 foot vertical spacing." He found that

> "the support system used was appropriate unless the soil is a Type C. However, I conclude that the excavation was in a Type B soil based upon the testimony of [employer], the opinion of the physical engineer and because the [enforcement officer] based his rating upon the weakest layer which, according to the [enforcement officer], was the bottom 6 feet of the trench, but the [enforcement officer] did not enter the trench to perform a close visual or manual test."

In its first assignment, OSHD argues that the referee erred in holding that the three-foot clearance between the bottom of the trench and the shoring support system was not a violation. It asserts that the referee either exceeded his authority by effectively deciding that the violation was harmless or erred by interpreting the rule as allowing an excavation greater than two feet if there is no evidence of soil loss.

We agree with petitioner that the referee incorrectly interpreted 29 CFR 1926.652(e)(2)(i) and erred in concluding that employer had not violated the rule. The rule provides:

> "Excavation of material to a level no greater than 2 feet (.61m) below the bottom of the members of a support system shall be permitted, but only if the system is designed to resist the forces calculated for the full depth of the trench, and there are no indications while the trench is open of a possible loss of soil from behind or below the bottom of the support system."

128 Or App 208> The referee's conclusion indicates that there was no violation, because there was no evidence of possible soil loss.

The referee apparently concluded that the rule permits excavations greater than two feet below a shoring system if there is no evidence of possible soil loss. However, the plain language of the rule permits the "[e]xcavation of material to a level *no greater than 2 feet* (.61m) below the bottom of the members of a support system" (emphasis supplied) only if two additional requirements are satisfied: the system is designed to resist the forces calculated for the full depth of the trench, and there are no indications of a possible loss of soil from behind or below the bottom of the support system. *See* 29 CFR 1926.652(e)(2)(i). In other words, the rule allows a clearance of two feet or less between the bottom of a trench and the bottom of a shoring system if the system is designed to resist the forces of the full depth of the trench and there is no evidence of possible soil loss.

The three feet of exposed soil between the bottom of the trench and the bottom of the shoring system violated the rule. The referee erred in dismissing citation 1-3.

In its second assignment, OSHD argues that the referee erred in concluding that the shoring system provided adequate protection from cave-ins. It first asserts that the referee misinterpreted the rules to require a nexus between the two violations. It further asserts that the referee erred by disregarding evidence that employer installed an insufficient number of shores. Finally, it asserts that the referee disregarded or misinterpreted a footnote to a rule that requires a minimum of three vertical shores.

The rule regarding the protection of employees in excavations provides:

> "Each employee in an excavation shall be protected from cave-ins by an adequate protective system designed in accordance with paragraphs (b) or (c) * * *." 29 CFR 1926.652(a)(1).

Paragraph (b) concerns the design of sloping and benching systems and does not apply to this case. Paragraph (c) describes the requirements for designs of support shield systems selected and constructed by the employer. It provides four alternative methods for determining the proper design. **<128 Or App 208/209>** *See* 29 CFR 1926.652(c)(1)-(4). The referee relied on Option (1) and Table 1.2 contained in Appendix D to the rule and concluded that employer's support system was adequate.

Table 1.2 contains the vertical shore requirements for aluminum hydraulic shoring for Type B soils. *See* 29 CFR 1926.652, Table D-1.2. According to the table, the maximum horizontal spacing permitted between shores is eight feet; the maximum vertical spacing is four feet. Footnote (g)(6) to the table requires a minimum of three shores spaced equally, horizontally when vertical shores are used, regardless of the soil type. 29 CFR 1926.652, Appendix D n (g)(6). The referee concluded that the support system used by employer was "adequate for the distances involved both horizontal[ly] and vertical[ly]."

We agree with employer that the referee did not misinterpret the rule as requiring a nexus between the violations. The referee found:

> "If citation item 1-3 is not a violation, citation item 2-8 is not a violation either because the number of cylinders used is adequate given an 8 foot vertical spacing. OAR 437-03-001 [29 CFR 1926.652(a)(1)], Appendix D, Table D-1.2."

That finding, albeit not a model of clarity, indicates that there was no violation because the number of cylinders used was adequate for the vertical spacing. The referee apparently only intended to refer to the facts common to the two citations. In addition, because OSHD has not separately assigned error to the referee's refusal to admit the manufacturer's tabulated data evidence, we will not consider that argument. ORAP 5.45(4).

Nevertheless, it is undisputed that the shoring system employer used contained only two vertical shores. In addition, the parties do not dispute that footnote (g)(6) requires a minimum of three vertical shores. There is no reason for us to remand for the referee to consider the requirements of the footnote. Employer's shoring system contained only two vertical shores. The referee erred in concluding that that system was not a violation.

Because we conclude that there was a violation of the shoring system requirement that there be a minimum of **<128 Or App 209/210>** three vertical supports, regardless of the soil type, we need not address petitioner's third assignment.

Reversed and remanded with instructions to reinstate citations 1-3 and 2-8.

Here, had the insurer "suspended" claimant's TTD payments following the receipt of Dr. Bitseff's report of September 17, 1990, I would hold that no TTD was "due and payable" after that date. However, the reality of this case is that the insurer never invoked the provisions of ORS 656.262(4) to "suspend" claimant's TTD benefits. Therefore, I would hold that, because the insurer never "suspended" benefits pursuant to ORS 656.262(b)(4), the statute has no application here, and that claimant's right to TTD continued until one of the provisions of ORS 656.268(3) was met. That occurred when claimant returned to work after December 24, 1990.

Cite as 128 Or App 466 (1994) June 22, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

PARKER FURNITURE, INC., dba Parker Furniture Design Center, Respondent,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below, and SAIF CORPORATION, Petitioner.
(91-04-034; CA A77446)

Judicial Review from Department of Insurance and Finance.

Argued and submitted September 27, 1993.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

O.R. Skopil, III, argued the cause for respondent Parker Furniture, Inc. On the brief were Gordon L. Welborn and Moscato, Byerly & Skopil.

Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.

DEITS, P.J.

Reversed and remanded for reconsideration.

*Haselton, J., *vice* Durham, J.

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128 Or App 468> SAIF seeks review of a Department of Insurance and Finance (DIF)[1] final order requiring it to rebill Parker Furniture, Inc., deleting charges for additional workers' compensation premiums. We reverse and remand.

This case arose in the context of a premium audit dispute between Parker Furniture, a wholesale and retail seller of furniture and carpet, and its insurer, SAIF Corporation. During the disputed period of October 1, 1989, to September 30, 1990, Parker Furniture arranged for installation of floor covering bought by its customers, if the customers so requested. Although Parker Furniture also used other installers, it normally arranged the installations with Smyd (installer). SAIF conducted an audit of Parker Furniture and charged it workers' compensation premiums for the amounts paid to installer. Parker Furniture appealed to DIF, arguing that installer was not subject to premium assessment.

DIF determined that installer was a "worker" based on the judicially created "right to control" and "nature of the work" tests. ORS 656.005(28). It then concluded that installer was a nonsubject worker within the meaning of ORS 656.027(7), because he was both an independent contractor, as defined by ORS 670.600, and a sole proprietor. SAIF assigns error to DIF's conclusion that installer was both a worker under ORS 656.005(28) and exempt as a sole proprietor under ORS 656.027(7).

When the basic facts are not in dispute, as is the case here, the question of employee or independent contractor status is one of law. *Woody v. Waibel*, 276 Or 189, 192 n 3, 554 P2d 492 (1976). In its recent opinion in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, ___ P2d ___ (1994), the Supreme Court formulated a method of analysis to be followed when determining a person's status for purposes of workers' compensation insurance. First, a determination is to be made as to whether the person is a "worker" under ORS 656.005(28). That statute provides, in pertinent part:

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[1] Since it issued the order in this case, DIF has been renamed the Department of Consumer and Business Services. *See* ORS 656.005(9).

> **128 Or App 469>** "'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *."

This initial determination incorporates the judicially created "right to control test." 318 Or at 630. Under the Supreme Court's analysis, if a person is not subject to the direction and control of an employer, the person is not subject to workers' compensation coverage because he or she is not a "worker." That is the end of the inquiry.

If the person is found to be a "worker," a determination is made as to whether the worker is "nonsubject" under one of the exceptions listed in ORS 656.027. One exception is for sole proprietors; however, the subsection providing for that exception states that "[w]hen labor services are performed under contract, the sole proprietor must qualify as an independent contractor." ORS 656.027(7). "Independent contractor" is defined in ORS 670.600, which sets out a list of criteria, all of which must be met to establish independent contractor status. Here, however, we need look no further than the first standard, which requires that the worker be "free from direction and control over the means of providing the labor or services." ORS 670.600(1). In *S-W Floor Cover Shop*, the court construed that provision to incorporate the same "right to control" test as was used to determine "worker" status; the provision does *not* require a test of "actual control." 318 Or at 630. Consequently, any person who is determined to be a worker under ORS 656.005(28) cannot be an independent contractor under ORS 670.600 and, thus, cannot be exempt as a sole proprietor under ORS 656.027(7).[2]

Applying the Supreme Court's analysis to this case, DIF correctly began the inquiry by evaluating whether installer was a "worker" under ORS 656.005(28). DIF applied the "right to control" test, *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989), and, finding that test **<128 Or App 469/470>** inconclusive, applied the "nature of the work" test. *See Reforestation General v. Natl. Council on Comp. Ins.*, 127 Or App 153, 166-67 and n 13, ___ P2d ___ (1994). DIF concluded that because installer was subject to Parker Furniture's direction and control, he was a "worker" during the period in dispute.[3] As discussed above, under the rule set out by *S-W Floor Cover Shop*, it must also follow that installer did not come within the exception for sole proprietors under ORS 656.027(7) and, therefore, was not a "nonsubject" worker.[4] We hold that DIF erred in concluding that installer was a nonsubject worker based on the exemption in ORS 656.027(7).

Reversed and remanded for reconsideration.

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[2] The Supreme Court recognized that its construction makes ORS 656.027(7) "unnecessary." *S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra*, 318 Or at 631. Although not explicitly mentioned by the court, its construction also makes ORS 670.600, defining independent contractor, unnecessary in the context of workers' compensation insurance.

[3] Parker Furniture does not challenge that finding.

[4] Parker Furniture does not argue that any of the other provisions under ORS 656.027 exempt installer from coverage.

Cite as 128 Or App 422 (1994) June 8, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald Cameron, Claimant.

RONALD **CAMERON**, Petitioner,
v.
NORCO CONTRACT SERVICE and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(91-07681; CA A78915)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 12, 1993.
Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.
Conway McAllister argued the cause for respondents. On the brief was James D. McVittie.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Reversed and remanded for award of temporary total disability benefits through December 24, 1990.
De Muniz, J., concurring.

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128 Or App 424> Claimant petitions for review of a Workers' Compensation Board order. He contends that the Board erred in concluding that claimant's benefits for temporary total disability (TTD) were not due and payable after July 16, 1990. He argues that he is entitled to TTD until December 24, 1990, the date his physician informed him that he was released for work. Both parties treat this as a termination case under ORS 656.262(4)(b). We reverse and remand.

Claimant compensably injured his right wrist on October 15, 1987. A subsequent injury to his left wrist was accepted as part of his right wrist claim. On July 16, 1990, claimant saw his treating physician, Dr. Bitseff. Bitseff did not tell claimant that he had released him for work on that date. On September 17, 1990, however, Bitseff reported to insurer that claimant was medically stationary and had been released for regular work on July 16. Bitseff next saw claimant on December 24, 1990, and gave claimant verbal authorization to return to work. He did not give claimant a written release.

A determination order closed claimant's claim on March 12, 1991, awarding him TTD through July 16, 1990. Claimant did not receive TTD after that date. The referee ordered that claimant be paid TTD through December 24, 1990, the date that he received verbal authorization to return to work. The Board concluded that claimant was entitled to TTD only until July 16, 1990.

Claimant contends that once statutory entitlement to TTD is established, it continues until one of the three events specified in ORS 656.268(3) occurs: (1) The worker returns to regular or modified work; (2) the treating physician provides the worker with a written release to return to regular work; or (3) the treating physician provides the worker with a written release to return to modified work, such work is offered in writing to the worker, and the worker fails to begin work. Claimant did not return to regular or modified work, and never received a written release from his physician.

Insurer argues that "an insurer may *also* unilaterally terminate temporary disability benefits under ORS **<128 Or App 424/425>** 656.262(4)(b), when the treating physician can no longer verify a claimant's inability to work as a result of his injury." (Emphasis in original.)[1] Because TTD was not authorized by claimant's attending physician, insurer contends that claimant was not entitled to TTD after July 16, 1990.

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[1] ORS 656.262(4)(b) provides:

"Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control."

The Board agreed with insurer. It held that ORS 656.262(4)(b) provides "a mechanism whereby an insurer or self-insured employer may unilaterally terminate a claimant's TTD when there is a continuing request for benefits and the insurer meets certain requirements."

In *Sandoval v. Crystal Pine*, 118 Or App 640, 643, 848 P2d 1224, *rev den* 317 Or 272 (1993), we held that the only means for an employer to unilaterally terminate TTD is pursuant to ORS 656.268(3). *See also United Airlines, Inc. v. Brown*, 127 Or App 253, 257, ___ P2d ___ (1994). Regarding the relationship between ORS 656.268(3) and ORS 656.262(4), we said in *Sandoval*:

> "ORS 656.262(4)(a) contemplates that TTD benefits are being paid and describes when they are payable to a claimant. ORS 656.262(4)(b) provides that TTD is not 'due and payable' when the attending physician is unable to verify the claimant's inability to work. In essence, it permits an insurer or self-insured employer to 'suspend' the payment of TTD until such verification is obtained. *However, the suspension of benefits pursuant to ORS 656.262(4)(b) does not terminate claimant's entitlement to TTD under ORS 656.268.*" 118 Or App at 644. (Emphasis supplied.)

The Board erred in holding that, under ORS 656.262(4), an insurer or self-insured employer may unilaterally terminate claimant's TTD.[2]

Reversed and remanded for award of temporary total disability benefits through December 24, 1990.

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[2] Claimant's other assignment of error is moot. *Ferguson v. U.S. Epperson Underwriting*, 127 Or App 478, ___ P2d ___ (1994).

128 Or App 426> DE MUNIZ, J., concurring.

I agree with the majority's result insofar as it holds that the Board erred in concluding that claimant was not entitled to TTD after July 16, 1990. I write separately, because I would analyze the issue somewhat differently than the majority does.

In *Sandoval v. Crystal Pine*, 118 Or App 640, 848 P2d 1224, *rev den* 317 Or 272 (1993), the employer, in October, 1990, requested that claimant's attending physician verify the claimant's continued inability to work. The attending physician's response, on November 5, 1990, did not verify the claimant's inability to work but, instead, suggested that the employer have claimant examined by another physician. The claimant was then examined by another physician who reported to the employer that the claimant was capable of returning to work. The employer stopped paying TTD as of December 18, 1990.

We held that the Board had correctly concluded that TTD was not due and payable after November 5, 1990, when the claimant's attending physician did not verify the claimant's continued inability to work. In discussing the relationship between ORS 656.268(3) and ORS 656.262(4), we said:

> "ORS 656.268 provides for termination of TTD and claim closure. The only means for an employer to unilaterally 'terminate' TTD is pursuant to ORS 656.268(3); the entitlement to those benefits continues until the requirements of the statute are met. *See Northrup King & Co. v. Fisher*, 91 Or App 602, 757 P2d 855, *rev den* 307 Or 77 (1988) (construing an earlier version of ORS 656.268).
>
> "ORS 656.262(4)(a) contemplates that TTD benefits are being paid and describes when they are payable to a claimant. ORS 656.262(4)(b) provides that TTD is not 'due and payable' when the attending physician is unable to verify the claimant's inability to work. In essence, it permits an insurer or self-insured employer to 'suspend' the payment of TTD until such verification is obtained. However, the suspension of benefits pursuant to ORS 656.262(4)(b) does not terminate claimant's entitlement to TTD under ORS 656.268. To read ORS 656.262(4)(b) as claimant suggests would read it out of existence. We hold that the Board was correct when it held that TTD was not due and payable after November 5, 1990." 118 Or App at 644.

Cite as 128 Or App 471 (1994) June 22, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CINDY LOU **PEASE**, dba Evans Farms, Petitioner,

v.

The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents.

(91-07-003; CA A78347)

Judicial Review from Department of Insurance and Finance.

Argued and submitted January 24, 1994.

J. Michael Alexander argued the cause for petitioner. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann.

Peter A. Ozanne argued the cause for respondent National Council on Compensation Insurance. With him on the brief was Schwabe, Williamson & Wyatt.

James W. Moller, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and Riggs and De Muniz, Judges.

RIGGS, J.

Affirmed.

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128 Or App 473> Employer seeks review of a Department of Insurance and Finance (DIF)[1] final order requiring employer to pay additional workers' compensation premiums to its insurer, SAIF. Employer challenges DIF's determination of what constitutes verifiable records, DIF's classification of certain employees as general nursery employees and DIF's classification of certain individuals as employees rather than independent contractors. We affirm.

Employer operates Evans Farm, an 180-acre ornamental plant nursery and retail garden store. Evans Farm has four locations. "Farm one" serves as employer's headquarters and includes employer's residence, as well as a converted barn with office space and a retail garden center. The garden center sells seeds, statuary, chemicals, garden supplies and plants that have been grown both at Evans Farm and elsewhere. The three other locations are all within a few miles of farm one and are used to grow nursery stock. Employer sells most of the nursery stock wholesale and some at her garden center.

Employer uses three types of workers that are involved in this review. First, employer employs a number of individuals to do a variety of tasks, including hand-hoeing. Very few of the hoers speak English, and most of them cannot read or write either English or their native language.[2] These employees turn in weekly time cards indicating the tasks done and the amount of time spent at each task. The time cards are filled out in Spanish, using Spanish terms, such as "azadon" or "zacate," to indicate hoeing. The cards are supposed to be filled out by the employee during the course of a day, but they are often filled out by other employees at unknown times.

Employer also employs a number of clerks for the retail garden store. They sell retail garden products, including plants grown on Evans Farm, to the public. Although employer asserts that the garden store is a separate entity, **<128 Or App 473/474>** she produced no evidence that she kept the books and records separate from the books and records of the entire business.

Finally, employer uses diggers to harvest plants from the ground and to prepare the plants for shipping. Employer leads the diggers to a field where other employees have marked off a block of plants to be dug. Employer tells the diggers the time frame in which the plants must be dug and negotiates a price per plant. The diggers then dig the trees and wrap the soil ball with burlap and twine. The soil ball is crucial to the plants' survival, and employer requires the diggers to meet certain standards of size and firmness in the plants' soil balls. Employer inspects the soil balls and either makes the digger comply with the standards or terminates the digger. The diggers are paid in round numbers every two weeks.

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[1] That department has been renamed the Department of Consumer and Business Services.

[2] Some of the hoers are native Spanish speakers and some speak other languages.

SAIF conducted a premium audit for the period January 1, 1990, through June 7, 1990, pursuant to ORS 737.318. Following the audit, employer appealed to DIF, ORS 737.505(3), and, after a hearing, DIF issued the final order of which employer seeks review. The order concluded that, as to the hoers, employer's records were not verifiable because they were kept in Spanish, no translation was provided to assist the auditors, and it was not clear when and by whom the time-cards were filled in. Because the records were not verifiable, employer was not allowed to allocate the payroll of her employees between the general business code and the less expensive code for hand-hoeing as allowed by ORS 737.310(10) and OAR 836-42-060. The order also classified the retail sales clerks payroll under Code 0005, Farm: nursery employees and drivers, instead of the code that employer requested, Code 8001, Store: florists and drivers.[3] Finally, the order concluded that because the diggers were employees, not independent contractors, employer owes premiums for the diggers' payroll during the audit period. We review for errors of law and substantial evidence. ORS 183.482(8)(a); ORS 183.482(8)(c).

Employer first challenges whether DIF had subject matter jurisdiction to hear this dispute, whether the hearings process deprived her of her constitutional right to trial by jury and whether the hearings officer correctly assigned the burden of proof to her. However, employer concedes that, in *Salem Decorating v. Natl. Council on Comp. Ins.*, 116 Or App 166, 840 P2d 739 (1992) *rev den* 315 Or 643 (1993), we decided those issues adversely to her position. She suggests no reason why those issues should be decided any differently here, and we conclude that DIF did not err in these respects.

Employer next assigns error to DIF's conclusion that the records she kept were not verifiable. ORS 737.310(10) authorizes DIF to issue rules prescribing the conditions under which an employer can divide payroll between different classification codes.[4] OAR 836-42-060(1) provides that one of those conditions is that an employer must provide "verifiable payroll records" disclosing the allocation of time spent at the different tasks. Neither the statutes nor the regulations set forth the requirements of "verifiable" payroll records. In the final order, DIF defined verifiable to mean

> "that the accuracy of the insured's classification and job description technique must be capable of independent confirmation by an insurer using records that are maintained by the employer and available to the insurer at the time of the audit."

DIF then found that, because employer's records were kept in Spanish, were not translated to assist the auditors and did not indicate when and by whom the time-cards were filled in, the records were not verifiable. Employer is correct that records kept in Spanish are not necessarily unverifiable. However, DIF also found that employer's time-cards "were completed by unknown persons some period of time after the time of work performance." DIF defined verifiability to include accuracy, and employer does not challenge that definition. DIF's interpretation of its own rule is entitled to deference and we accept it. *See Booth v. Tektronix*, 312 Or 463, 473, 823 P2d 402 (1991); *Branscomb v. LCDC*, 297 Or 142, 145, 681 P2d **<128 Or App 475/476>** 124 (1984); *Springfield Education Assn. v. School Dist.*, 290 Or 217, 221, 621 P2d 547 (1984). Therefore, the records, to be verifiable, must also be accurate. The lack of contemporaneous time-cards and the uncertainty as to who filled them out led DIF to conclude that the time-cards could not be audited for accuracy and, thus, were unverifiable. DIF's conclusion that employer's records were unverifiable was not error.

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[3] The codes at issue are determined by the National Council on Compensation Insurance (NCCI). NCCI is a licensed rating organization for workers' compensation insurance that classifies businesses and sets rates. The classifications and rates are filed with and approved by DIF and used by the insurer to determine the premiums that it charges individual businesses. See OAR 836-42-02; OAR 836-42-045.

[4] ORS 737.310(10) provides:

> "The director, by rule, shall prescribe the conditions under which a division of payroll between different manual classifications is permitted for purposes of computing workers' compensation premiums."

Employer next assigns error to DIF's assignment of Code 0005 to the clerks in the retail garden center. She contends that those employees should be assigned to code 8001 for "store: florist and drivers." However, the basic rating system classifies payrolls by the employer's business, not by the various employments, occupations or operations within that business.5 *Mr. Lustre Car Care v. Nat'l Council on Comp Ins.*, 99 Or App 654, 657, 783 P2d 1032 (1989). Code 0005 applies to "insureds engaged primarily in the propagation of trees, shrubs, plants and flowers for retail and wholesale sale." Employer concedes that this "may generally describe much of the insured's operation," but she contends that the retail garden center is a separate entity and should be classified as such. Rule IV-D-4 in the Basic Manual of Worker's Compensation and Employer's Liability[6] allows a business to have a second classification code for a separate entity, provided certain qualifications are met. The second business must be conducted as a separate undertaking, separate payrolls must be maintained and the businesses must be physically separated with no interchange of labor. The hearings officer found that "[employer's] four farms are still one **<128 Or App 476/477>** nursery location" and that "[employer's] retail garden sales are not a secondary business, but an incident of its primary business." In addition, although employer testified that she maintained separate books and payroll, she did not place those records in evidence, and the hearings officer found her testimony not credible. Accordingly, the final order correctly determined that employer was not entitled to have her retail garden center employees assigned to a separate code.

Employer next assigns error to the conclusion that the diggers were employees for purposes of worker's compensation premiums. She does not challenge the facts found by DIF, but argues, instead, that DIF misapplied the "right to control" test. The question of employee or independent contractor status is one of law if the basic facts are not in dispute. *Woody v. Waibel*, 276 Or 189, 192 n 3, 554 P2d 492 (1976); *Reforestation General v. Natl. Council on Comp. Ins.*, 127 Or App 153, 165, P2d (1994). The Supreme Court recently held that the judicially created "right to control" test is the starting point for determining whether an individual is a "worker" under ORS 656.005(28) and thus subject to the workers' compensation laws. *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 630, ___ P2d ___ (1994). That test has four primary factors: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989).

Employer first argues that DIF incorrectly determined that there was direct evidence of the right to control the diggers' work. She argues that she had "no control over their hours, or even the particular days they might work." Although employer may be correct that she did not control the diggers' hours and days, that is not dispositive. The right to control the details of the method of performance is another substantial aspect of this factor. *See S-W Floor Cover Shop v. Natl Council on Comp. Ins., supra*, 318 Or at 622. DIF found:

> "*Direct evidence of the right to, or exercise of, control*: * * * [employer] instructed the diggers what plants to dig and when. [Employer] required that the diggers create the soil ball in conformance with OAN [Oregon Association **<128 Or App 477/478>** of Nurserymen] standards. [Employer] inspected the diggers' work. If the diggers were not at work, [employer] replaced them. If a digger's work failed to meet industry standard, [employer] terminated the digger's employment immediately. If the work failed to meet the industry standard but was capable of correction, [employer] told the digger to correct the work. These factors indicate an employer/employee relationship."

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5 That is not inconsistent with the issue discussed above involving the hoers. A business will be assigned one code, which describes its general business. In most cases, all of an employer's employees will be classified according to that one code. However, the NCCI rating system also includes a few special codes that are applicable across different employers' general business codes. One of those codes is 0008 for hand-hoeing. If a business has employees who perform those tasks, and it can meet the requirements, such as maintaining verifiable records, then the employer can allocate a particular employee's payroll to the general business code as well as the specific task code. If no employee performs those tasks, or if the employer does not meet the requirements, then the entire payroll is assigned to the general business code.

6 The Basic Manual of Workers' Compensation and Employers' Liability includes rules that guide NCCI's interpretation and application of the classifications. *Douglas Co. Farmer's v. Natl Council on Comp. Ins.*, 119 Or App 69, 71, 849 P2d 1144 (1993).

Employer controlled the details of how the work was performed, she set the standards of how the soil ball was to be dug, she inspected the soil balls, she determined which plants were going to be worked on and she told the diggers when they needed to be finished. DIF correctly determined that this factor indicated an employer/employee relationship.

Employer next argues that DIF erroneously found that the method of payment was consistent with employee status and not independent contractor status. However, DIF actually found that this factor supported both conclusions, and thus was inconclusive. In the final order, DIF found:

> "*The method of payment*: [Employer] paid the diggers every two weeks. The payments were in round numbers, such as $700. Each digger received an even amount of money, when [employer] allegedly paid them according to the number of harvested trees. This is more indicative of payments for continuing services than payment on a piece-work basis. Further, [employer] set the rates with the group, for the group, and within the guidelines of the OAN. This method of price setting is not negotiation by two parties of equal bargaining positions. These factors are indicative of an employer/employee status.
>
> "[Employer] used a federal tax reporting form 1099 to report its payments to the diggers. This factor is indicates an independent contractor relationship."

DIF correctly found that the method of payment factor is inconclusive in this case.

Employer next argues that an analysis of the right to fire supports the conclusion that the diggers were independent contractors. Regardless of whether DIF found that the right to fire supported a conclusion that the diggers were independent contractors or employees, the other factors of the right to control test indicate that this test is inconclusive.

128 Or App 479> When the right to control test is inconclusive, DIF may proceed to the "relative nature of the work" test to determine whether an employment relationship exists. *S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra,* 318 Or at 622 n 6; *Henn v. SAIF,* 60 Or App 587, 593, 654 P2d 1129 (1982), *rev den* 294 Or 536 (1983). DIF properly did so and found that, under this test, the diggers were employees. The relative nature of the work test involves an examination of

> "the character of the claimant's work or business - how skilled it is, how much a separate calling or enterprise it is, to what extent it may be expected to carry its own accident burden and * * * its relation to the employer's business, that is, how much it is a regular part of the employer's regular work, whether it is continuous or intermittent, and whether the duration is sufficient to amount to the hiring of continuing services as distinguished from contracting for the completion of a particular job." *Woody v. Waibel, supra,* 276 Or at 195 (quoting 1A Larson's *Workmen's Compensation Law* 43.51 (1973)).

DIF found that the diggers' work was seasonal, but was a regular part of employer's business. DIF also found that the diggers' work was necessary for employer to pursue her business, that the same diggers worked for her from year to year and that she hired some of the diggers as employees after the digging season ended. We agree with DIF's conclusion that under the relative nature of the work test, the diggers were employees and not independent contractors.

Affirmed.

Cite as 128 Or App 579 (1994) June 22, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CY INVESTMENT, INC., dba Cy's Parkrose Pub, Respondent,
v.
The filing of **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below, and
SAIF CORPORATION, Petitioner.
(91-08-055; CA A76775)

Judicial Review from Department of Insurance and Finance.

Argued and submitted May 26, 1993.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Peter A. Ozanne argued the cause for respondent. With him on the brief was Schwabe, Williamson & Wyatt.

Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.

HASELTON, J.

Reversed and remanded for reconsideration.

*Haselton, J., *vice* Durham, J.

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128 Or App 581> SAIF Corporation seeks review of an order of the Department of Insurance and Finance (DIF)[1] determining that 22 dancers at Cy's Parkrose Pub are not "workers" and, therefore, are not subject to workers' compensation coverage. We remand for DIF to apply the "nature of the work" test in determining the dancers' status.

The material facts are undisputed. Cy's employs dancers as entertainment for its tavern customers. During the premium period of July 1, 1989, to June 30, 1990, Cy's identified prospective dancers through advertisements and auditions. Dancers who passed auditions selected the time, date, and frequency of their work by signing up for shifts on a weekly schedule that Cy's maintained. Such flexibility was important to the dancers: many performed at other establishments. Indeed, about half of the 22 dancers Cy's hired used agents to obtain their bookings.

Cy's paid the dancers a fee for each shift worked, which amounted to an average of $6 per hour, and reported that compensation to the IRS as "non-employee compensation" on Form 1099s. At the end of each shift, each dancer signed a form "contract" indicating the hours of her performance and the amount of compensation earned. That form also stated that the dancer was responsible for her own taxes and workers' compensation. In addition to their wages, the dancers received substantial tips, which exceeded their wages. The dancers generally reported their compensation on Schedule C forms, deducting business expenses, the costs of costumes, tanning and professional grooming.

The dancers had substantial freedom with respect to the manner and content of their individual performances. Cy's did not specify the costume or the music that the dancers must use; dancers who did not provide their own music were required to pay Cy's $2 per shift to use Cy's juke box.

Cy's did, however, exercise a general degree of control over the dancers' performance. Cy's required the dancers to alternate between dancing four songs, and then sitting out four songs, during their shifts. Moreover, Cy's fined the **<128 Or App 581/582>** dancers for failing to confirm their scheduled appearances, tardiness, failing to complete their shift, and touching the mirrors on employer's stage. The dancers' form "contract" denominated those fines as "liquidated damages."[2]

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[1] DIF is now known as the Department of Consumer and Business Services.

[2] The "mirror rule" appears to have been based on simple housekeeping concerns: The employer apparently spent an inordinate amount of time cleaning its mirrors.

After considering those facts, DIF concluded that the dancers were not "workers" within the meaning of *former* ORS 656.005(27).[3] In so concluding, DIF relied exclusively on the common law "right to control" test. DIF did not apply or address the "nature of the work" test of worker status.

SAIF disputes DIF's ultimate conclusion that the dancers were not workers. *Former* ORS 656.005(27) defined a worker as

> "*any person* * * * who engages to furnish services for a remuneration, *subject to the direction and control of an employer* * * *." (Emphasis supplied.)

Whether a person is "subject to the direction and control of an employer" within the meaning of the statute is initially considered under the "right to control" test.[4] *McQuiggin v. Burr*, 119 Or App 202, 207, 850 P2d 385 (1993). The right to control, rather than the actual exercise of control, is dispositive. See *Collins v. Anderson*, 40 Or App 765, 769, 596 P2d 1001 (1979). Where application of the "right to control" test proves inconclusive, "worker" status is to be determined by reference to the "nature of the work" test. *See Woody v. Waibel*, 276 Or 189, 197, 554 P2d 492 (1976).

The principal factors in the "right to control" test are:

> "(1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and **<128 Or App 582/583>** (4) the right to fire." *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989).

None of those factors is dispositive; rather, they are to be viewed in their totality. Where, as here, the parties do not dispute the basic facts, the question of employee status is one of law. 95 Or App at 271.

With respect to the first factor, the pertinent consideration is the employer's control over the method of performance, as opposed to control over the result to be reached. *See Great American Ins. v. General Ins.*, 257 Or 62, 68, 475 P2d 415 (1970). There is direct evidence that Cy's exercised some right of control over the method of the dancers' performances. For example, Cy's defined the length of the dancers' shifts, specified the number of songs to be performed, and fined the dancers for violating its rules (including the "mirror" rule).[5] Other evidence suggests that the dancers exercised primary control over the manner of their performance. The employer did not control when or how frequently the dancers worked because the dancers scheduled themselves. Moreover, employer did not prevent the dancers from working for its competitors and did not specify the dancers' costumes, music, or dance routines. *See Woody v. Waibel, supra*, 276 Or at 192 n 2. On balance, this factor is inconclusive.

The second, "method of payment" factor is similarly inconclusive. The dancers separately contracted with respect to each shift and were paid a fee for completing a shift. Although the fee could be broken down into a per hour rate, and the form "contract" appears to contemplate payment for part performance, it is unclear whether Cy's ever paid any dancer for performing less than a full shift. Moreover, although the parties' own characterization of their relationship is not dispositive, both Cy's, through its filing of Form 1099s, and the dancers, through their filings of Schedule Cs and their associated deductions of business expenses, treated their relationship as one of employer and independent contractor. *Accord McQuiggin v. Burr, supra*, 119 Or App at 207 (although the parties' view of the nature of their relationship is not controlling, "in a close case, it may swing the balance").

128 Or App 584> The third, "provision of equipment" factor supports DIF's determination that the dancers were not "workers." The dancers provided their own costumes and either provided their own music or paid Cy's for the use of its juke box. Moreover, although Cy's provided the stage, the stage was not equipment in its ordinary sense, but was, instead, merely the site of the dancers' performance.

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[3] *Former* ORS 656.005(27) has been renumbered ORS 656.005(28). Or Laws 1990, ch 2, 3.

[4] SAIF argues that because of the intervening enactment of ORS 656.005(29), which became effective on October 3, 1989, and which incorporated the definition of "independent contractor" set out in ORS 670.600, we should apply ORS 670.600 in determining coverage of the dancers for that portion of the premium year after October 3, 1989. *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 872 P2d 1 (1994), forecloses this argument.

[5] Cy's characterization of the penalties for violation of its rules as "liquidated damages," rather than fines, seems contrived and is unpersuasive.

Finally, the "right to fire" factor is inconclusive. There is no evidence that Cy's ever terminated a dancer in mid-shift. Moreover, although Cy's retained, and exercised, the ability not to invite dancers back, there is no evidence that Cy's ever prevented a dancer from working a previously-scheduled shift. On the other hand, because the work "contracted" for is of such limited duration, Cy's ability to prevent a dancer from signing up for additional shifts approaches a "right to fire" even if Cy's never actually prevented a dancer from working a previously scheduled shift.

Thus, the "right to control" inquiry is inconclusive. Although the "provision of equipment" factor supports a characterization of the dancers as independent contractors and not workers, the other three factors are closely balanced. Given those circumstances, we decline to give dispositive weight to the "provision of equipment" factor:

> "For the most part, any single factor is not merely indicative of, but, in practice, virtually proof of, the employment relation; while, on the opposite direction, contrary evidence as to any one factor is at best only mildly persuasive evidence of contractorship, and sometimes is of almost no such force at all." 1B Larson, *Law of Workman's Compensation* 8-90, 44.31 (1990).

Because the "right to control" test is inconclusive, DIF erred in basing its determination that the dancers were not "workers" on that test. We remand for DIF to apply the "nature of the work" test and to make additional findings, if necessary. *See Woody v. Waibel, supra*, 276 Or at 197; *Premsingh & Assoc. v. Natl. Council on Comp. Ins.*, 111 Or App 624, 627, 826 P2d 120, *rev den* 313 Or 300 (1992).

Reversed and remanded for reconsideration.

Cite as 128 Or App 585 (1994) June 22, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CHARLES E. **HORN**, Appellant,
v.
SEACATCHER FISHERIES, INC., a Washington corporation, and EMERALD RESOURCE MANAGEMENT, INC., a Washington corporation, Respondents.
(9303-02021; CA A80715)

Appeal from Circuit Court, Multnomah County.
George M. Joseph, Senior Judge.
Argued and submitted May 6, 1994.
Kevin Keaney argued the cause for appellant. With him on the brief were Kimberley Chaput, Robert K. Udziela and Pozzi, Wilson & Atchison.
Rex Armstrong argued the cause for respondents. With him on the brief was Bogle & Gates.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
HASELTON, J.
Affirmed.

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128 Or App 587> Plaintiff appeals the dismissal of his maritime personal injury action for lack of personal jurisdiction. We affirm.

The material jurisdictional facts are undisputed. Defendant Seacatcher Fisheries, Inc., is a Washington corporation that owns the fishing vessel F/T HEATHER SEA. Defendant Emerald Resources Management, Inc. (Emerald), managed the HEATHER SEA in 1990, when the conduct relevant to plaintiff's claims occurred. Neither defendant is registered to do business in Oregon, maintains offices or employees in Oregon, or leases or owns property in Oregon. The HEATHER SEA has never fished in Oregon waters or had any continuing contact with Oregon.

In early 1990, Emerald placed advertisements in *The Oregonian*, seeking crew members for the HEATHER SEA. Plaintiff, an Oregon resident, responded to these advertisements and was interviewed by an Emerald representative at an Oregon State Employment Division office in Portland. The Emerald representative subsequently called plaintiff at his home in Oregon and offered him a job as a crew

member of the HEATHER SEA. Plaintiff accepted that offer and flew at Emerald's expense to Alaska, where he joined the HEATHER SEA at Dutch Harbor.[1]

In April and May 1990, plaintiff allegedly sustained personal injuries while working on board the HEATHER SEA. Plaintiff brought this action for his injuries in Multnomah County Circuit Court, asserting claims for negligence under the Jones Act, 46 USC 688, and for unseaworthiness. Plaintiff argued that defendants were subject to the circuit court's jurisdiction under ORCP 4L. The circuit court rejected that argument, and dismissed plaintiff's complaint for lack of personal jurisdiction.

On appeal, plaintiff relies exclusively on ORCP 4L. That "catch-all" provision provides for personal jurisdiction over a defendant:

> **128 Or App 588>** "Notwithstanding a failure to satisfy the requirement of sections B. through K. of this rule, in any action where prosecution of the action against a defendant in this state is not inconsistent with the Constitution of this state or the Constitution of the United States."

State ex rel Circus Circus Reno, Inc. v. Pope, 317 Or 151, 854 P2d 461 (1993), frames our jurisdictional inquiry. There, the court adopted a two-part test for determining whether, in accordance with ORCP 4L, an exercise of jurisdiction over a non-Oregon defendant comports with due process:

> "First, the defendant must have 'minimum contacts' with the forum state. 'Minimum contacts' will be found where the defendant has 'purposefully directed' its activities at residents of the forum state *and* where the litigation 'arises out of or relates to' those activities. * * * Second, even if minimum contacts exist, the exercise of jurisdiction must be reasonable; in the light of various factors deemed relevant by the Court, the exercise of jurisdiction must comport with 'fair play and substantial justice.'" 317 Or at 159-60. (Quoting *Burger King Corp. v. Rudzewicz*, 471 US 462, 472, 476-77, 105 S Ct 2174, 85 L Ed 2d 528 (1985).) (Emphasis in original; citation omitted.)

Here, defendants do not dispute that they "purposefully directed" their recruiting and hiring activities at Oregon residents, including plaintiff. Indeed, those activities are closely analogous to the advertising and solicitation activities that established "purposeful direction" in *State ex rel Circus Circus Reno, Inc. v. Pope, supra.*[2]

The jurisdictional dispute turns, instead, on the second, "arising out of or relating to" minimum contacts element. Plaintiff contends that his claims "related to" his employment status which, by virtue of defendants' conduct, originated in Oregon.

We disagree. Assuming *arguendo* that the employment relationship was created in Oregon,[3] defendants' **<128 Or App 588/589>** conduct in recruiting and hiring plaintiff has no "substantive relevance" to plaintiff's personal injury claims. See State ex rel Michelin v. Wells, 294 Or 296, 303, 657 P2d 207 (1982). Although plaintiff's status as an employee at the time he was allegedly injured is a material element of his Jones Act claim,[4] allegations pertaining to the *creation* of the employment relationship are immaterial to the personal injury gravamen of that claim and, hence, cannot support jurisdiction:

> "'A contact is related to [a] controversy if it is the geographical qualification of a fact relevant to the merits. A forum occurrence which would ordinarily be alleged as part of a comparable domestic complaint is a related contact. In contrast, an occurrence in the forum State of no relevance to a totally domestic cause of action is an unrelated contact,

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[1] Plaintiff executed a "Crew Member Contract" on March 2, 1990. The record does not show where plaintiff was when he signed that contract. The contract bears a notation by the HEATHER SEA's manager that Seattle was plaintiff's "point of hire," but it is not apparent when, or under what circumstances, that notation was made.

[2] In *State ex rel Circus Circus Reno, Inc. v. Pope, supra,* Circus Circus advertised its facilities in an Oregon newspaper, provided brochures to the plaintiff's Oregon travel agent, a toll-free telephone information service to Oregon residents, and telephoned the plaintiff in Oregon to confirm his hotel reservation.

[3] It is unclear where the employment relationship was created. *See* note 1, *supra.*

[4] The parties do not address the materiality of plaintiff's employment status to his unseaworthiness claim.

> a purely jurisdictional allegation with no substantive purpose. If a fact is irrelevant in a purely domestic dispute, it does not suddenly become related to the controversy simply because there are multistate elements.'" *State ex rel Michelin v. Wells, supra,* 294 Or at 302, *quoting* Brilmayer, *How Contacts Count: Due Process Limitations on State Court Jurisdiction,* 1980 Sup Ct Rev 77, 82-83 (1980).

Circus Circus Reno is similar. There, a liquor bottle thrown from the defendant's hotel struck and injured the plaintiff. Although the plaintiff would not have been in Reno (and, thus, in a position to be struck by the bottle) but for Circus Circus's Oregon advertising and solicitation activities, the court held that the plaintiff's injuries did not arise out of or relate to the defendant's activities in Oregon. Instead, those injuries arose from the defendant's alleged negligence, including failure to keep the hotel windows bolted and failure to warn, that occurred in Nevada. In so holding, the court expressly declined the plaintiff's invitation to apply a "but for" test to the "arise out of or relates to" element.

So too here. Although plaintiff would not have been aboard the HEATHER SEA but for defendants' recruiting and hiring activities in Oregon, his alleged injuries arose out of and related to defendants' alleged negligence, including failure to provide adequate equipment and inadequate **<128 Or App 589/590>** instruction, which occurred in Alaskan and international waters.[5]

Finally, plaintiff argues that, regardless of the particular application of the "arises out of or relates to" requirement, asserting jurisdiction over these defendants would broadly comport with "traditional notions of fair play and substantial justice" because defendants who recruit Oregon residents to perform highly dangerous seasonal work "should reasonably anticipate being haled into" Oregon courts to defend suits by injured Oregon resident workers. *World-Wide Volkswagon Corp. v. Woodson,* 444 US 286, 292, 297, 100 S Ct 559, 62 L Ed 2d 490 (1980). Whatever the visceral appeal of plaintiff's argument, it flows from a false premise. *World-Wide Volkswagon's* "reasonable anticipation" formulation and *Burger King's* "minimum contacts" analysis as construed and applied in *State ex rel Circus Circus Reno, Inc. v. Pope, supra,* do not describe alternative tests for exercising long-arm jurisdiction. Instead, the two are congruent. The "minimum contacts" analysis defines when the "reasonable anticipation" requirement is satisfied:

> "By requiring that individuals have 'fair warning that a particular activity may subject [them] to the jurisdiction of a foreign sovereign,' the Due Process Clause gives a degree of predictability to the legal system that allows potential defendants to structure their primary conduct with some minimum assurance as to where that conduct will and will not render them liable to suit.
>
> "Where a forum seeks to assert specific jurisdiction over an out-of-state defendant who has not consented to suit there, *this 'fair warning' requirement is satisfied if* the defendant has 'purposefully directed' his activities at residents of the forum, and the litigation results from alleged injuries that 'arise out of or relate to' those activities." *Burger King Corp. v. Rudzewicz, supra,* 471 US at 472. **<128 Or App 590/591>** (Emphasis supplied; citations omitted.)

Because plaintiff's alleged personal injuries did not arise out of or relate to defendants' recruiting and hiring activities in Oregon, defendants did not have fair warning that they might have to defend this suit in Oregon. Defendants are not subject to jurisdiction under ORCP 4L.[6]

Affirmed.

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[5] *Cf. Coats v. Penrod Drilling Corp.,* 5 F3d 877 (5th Cir 1993), *cert den* ___ US ___, 114 S Ct 1303, *reh'g en banc granted* 20 F3d 614 (5th Cir 1994) (foreign corporation that recruited employees in Mississippi was subject to suit in Mississippi by Mississippi resident employee who was injured in the defendant's service in foreign waters; in addition to recruiting activities in Mississippi, the defendant corporation had contracted to return the plaintiff to Mississippi once a year and, after the plaintiff's injury, had flown the plaintiff back to Mississippi and paid for his medical treatment in Mississippi). The jurisdictional analysis in *Coats v. Penrod Drilling Corp., supra,* focuses on "purposeful availment" and does not expressly analyze the "arising out of" component of the minimum contacts inquiry.

[6] Plaintiff argues for the first time in his reply brief that the circuit court erred in denying plaintiff's motion to compel production of documents pertaining to defendants' activities in Oregon. That ruling was not assigned as error, and we do not consider it. ORCP 5.45(2).

Cite as 128 Or App 625 (1994) June 22, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DEBORAH KAREN **MAINS**, Appellant,
v.
II MORROW, INC., Respondent,
and TIM BERRY, Defendant.
(90C-12044-5; CA A73240)

Appeal from Circuit Court, Marion County.
Duane R. Ertsgaard, Judge.
Argued and submitted December 18, 1992.
J. Michael Alexander argued the cause for appellant. With him on the briefs was Burt, Swanson, Lathen, Alexander & McCann.
Scott J. Fortmann argued the cause for respondent. With him on the brief were Richard F. Liebman and Lane, Powell, Spears, Lubersky.
Before Richardson, Chief Judge, and Deits, Judge, and Durham, Judge pro tempore.
DURHAM, J. pro tempore.
Reversed and remanded on claims for intentional infliction of emotional distress and statutory sexual discrimination; otherwise affirmed.

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128 Or App 627> Plaintiff appeals from summary judgment for defendant II Morrow Corporation[1] on plaintiff's claims for employment discrimination on the basis of sex, disability and filing a workers' compensation claim, for intentional infliction of emotional distress and for wrongful discharge. We reverse as to the claims for sex discrimination and for intentional infliction of emotional distress, and otherwise affirm.

We view the record in the light most favorable to plaintiff, drawing all reasonable inferences in plaintiff's favor, to determine whether defendant established that there are no genuine issues of material fact and that it is entitled to judgment as a matter of law. ORCP 47C; *Seeborg v. General Motors Corporation*, 284 Or 695, 699, 588 P2d 1100 (1978). A factfinder could infer from the record that plaintiff's supervisor, Berry, harassed her at work because of her gender and created an environment in which he and other employees sexually harassed plaintiff on a daily basis. Berry was defendant's shop supervisor. Although he routinely allowed the male employees to select their job assignments, he rarely gave plaintiff a choice. Berry repeatedly made sexual comments and jokes, referred to plaintiff as a "sex-atary" and told her that she was "just another worthless woman." Plaintiff testified at her deposition:

> "I can't give you a certain day that this was, because it was on a daily thing. It was a general -- general atmosphere of the shop. Okay. Number 1, Tim Berry was the one who used the comment 'lick my balls' the most often. He would say things to the other guys in the shop like, 'I bet you wish you were a dog so you could lick your own balls.'"

Plaintiff also testified:

> "[Berry] called me a snippy bitch one day, and I told him then, 'You shouldn't have said that, [Berry].' And throughout my employment, I was called a wench by almost every one of the guys. When I would walk in there, 'Oh, there's the wench.' And I hated it, but Tim encouraged it. * * * [O]ne time [Berry] was giving me a really hard time, and I said what **<128 Or App 627/628>** -- 'Why are you treating me like that?' And he goes, 'Because I hate rich bitches.'"

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[1] We refer to II Morrow Corporation as defendant in this opinion. Defendant Berry is not a party to this appeal. The trial court granted summary judgment for defendant on all claims, and entered a judgment for defendant pursuant to ORCP 67B.

On another occasion, Berry told plaintiff, "You must be catching AIDS from your boyfriend or something, you're so sickly all the time." On several occasions, Berry emerged from the bathroom, and said "I was just taking a Karen [plaintiff's first name]." When a male co-worker apologized for swearing in front of plaintiff, Berry told him "You can use that word around her any time you want. She's not a lady. My wife's a lady." On one occasion, a co-worker touched plaintiff's breast in a harassing manner. When she reported that incident to Berry, he trivialized it and took no action. Plaintiff testified that Berry said

> "something to the effect that, 'Maybe he's getting courageous now that he's quitting soon' or something like that. But I don't know of him taking [the co-worker] into his office and talking to him about that * * *."

Berry physically harassed plaintiff as well. He shoved her and grabbed her ankles. He stood in front of plaintiff's car to delay her departure at lunchtime and encouraged two other employees to do the same thing. He did not treat male employees in that manner.

Although plaintiff repeatedly protested these actions to Berry, the harassment continued. He explained that, if he did not harass her, "the guys would get really mad" at him. When plaintiff suggested that she might report his conduct to defendant's personnel supervisor, Berry warned that

> "that would be the wrong thing to do. [The personnel supervisor] doesn't have that much clout. And besides, if you do that, that will be a reason to fire you."

A factfinder could infer that defendant was aware of Berry's conduct and failed to correct it. Following an earlier sexual harassment complaint, the Bureau of Labor and Industries investigated and required defendant to place a warning letter in Berry's file. However, he retained his supervisory position. Moreover, plaintiff testified:

> "[W]hen I first started working there, all the women came up to me * * * and said, 'How can you work for [Berry]? He's terrible. He's horrible. He hates women. He puts them down **<128 Or App 628/629>** like crazy. He's a male chauvinist pig.' * * * From my first day there, I heard about his reputation."

Ultimately, plaintiff reported Berry's behavior to defendant's personnel supervisor, who placed plaintiff on paid leave. Following an investigation, defendant terminated Berry and asked plaintiff to return to work. Defendant offered to "attempt to find other suitable and available employment" if plaintiff did not want to return to her former position. Plaintiff refused to return and filed this action.

The trial court granted defendant's motion for summary judgment on plaintiff's claims for intentional infliction of emotional distress, sex discrimination and wrongful discharge, because plaintiff did not "demonstrate the responsibility of Defendant II Morrow." The court also held that plaintiff's claims for employment discrimination stemming from the workers' compensation claim were barred by the statute of limitations.

We first address plaintiff's claim that the court erred in dismissing her wrongful discharge claim. Defendant argues that plaintiff cannot sustain her claim of wrongful discharge, because she quit after defendant terminated Berry. Plaintiff asserts that she was constructively discharged. An employer is liable for a constructive discharge if an employee resigns because of intolerable working conditions that a supervisor creates with the intent to force the employee to resign, and the employer is responsible for the conditions under the doctrine of *respondeat superior*. *Carlson v. Crater Lake Lumber Co.*, 105 Or App 314, 316, 804 P2d 511 (1991); *see also Bratcher v. Sky Chefs, Inc.*, 308 Or 501, 505, 783 P2d 4 (1989); *Sheets v. Knight*, 308 Or 220, 227, 779 P2d 1000 (1989).

Plaintiff argues that the intolerable working conditions remained, despite Berry's termination. However, plaintiff never explained what those intolerable conditions were. When asked whether she had quit, plaintiff testified:

> "I said 'I can't come back under these terms, and I can't come back anyway because of [Berry's] termination.' And so I don't know if you consider that I quit or that I was terminated or what."

128 Or App 630> Plaintiff did not explain, let alone put on evidence of, her reason for rejecting employer's repeated reinstatement offers. She did not suggest that the reinstatement offer was a pretext

designed to cover up further discrimination, or would restore her to a work environment that no reasonable employee would tolerate. She did not identify other employees who, despite Berry's firing, predictably would continue to harass her because of her gender, because of hostility for her role in the events that led to Berry's discharge, or for any other reason. Because her reluctance to return to work was not based on conditions that would support an inference of a constructive discharge, the trial court did not err in dismissing the wrongful discharge claim.

Plaintiff also assigns error to the court's conclusion that her claim for harassment for filing a workers' compensation claim is barred by the statute of limitations. The statute of limitations for that claim is one year. ORS 659.121(3). Plaintiff filed her complaint on October 19, 1990. She argues that the discriminatory conduct was her constructive discharge in May 1990. We have concluded that plaintiff has not offered evidence of a constructive discharge. She alleged no other conduct that occurred after January 1989, in support of her claim. The court correctly granted summary judgment on this claim.

Plaintiff assigns error to the dismissal of her tort claim for intentional infliction of emotional distress. To support this claim, plaintiff must show that defendant intended to inflict severe mental or emotional distress on her, that defendant caused her severe distress, and that defendant's conduct was an "extraordinary transgression of the bounds of socially tolerable conduct" or exceeded "any reasonable limit of social toleration." *Patton v. J.C. Penney Co.*, 301 Or 117, 122, 719 P2d 854 (1986). Plaintiff's evidence shows that Berry repeatedly harassed and demeaned her because of her gender, that he harassed her both verbally and physically, and that his actions caused plaintiff to suffer severe emotional distress. A jury could conclude that this conduct extraordinarily transgressed "the bounds of socially tolerable conduct" or "exceeded any reasonable limit of social toleration." Moreover, from the extent of his harassment, a jury could infer that Berry intended to cause plaintiff severe **<128 Or App 630/631>** emotional distress. *See Palmer v. Bi-Mart Company*, 92 Or App 470, 758 P2d 888 (1988). Because plaintiff's evidence raised factual questions about whether Berry's conduct was tortious, the remaining question is whether defendant is responsible for that conduct.

Defendant contends that, as a matter of law, it is not responsible for Berry's conduct. We separately discuss defendant's responsibility under plaintiff's tort theory and her statutory sex discrimination theory, because the standards for employer responsibility are not identical.

An employer is liable for an employee's tortious conduct if the employee acted within the "scope of employment." *Carlson v. Crater Lake Lumber Co., supra*, 105 Or App at 316. To make that determination, we apply a three-part test:

> "(1) [W]hether the act occurred substantially within the time and space limits authorized by the employment; (2) whether the employee was motivated, at least partially, by a purpose to serve the employer; and (3) whether the act is of a kind which the employee was hired to perform." Chesterman v. Barmon, 305 Or 439, 442, 753 P2d 404 (1988).

Vicarious liability is imposed, regardless of whether the employer committed a morally wrongful act, as a policy of risk allocation. *Farris v. U.S. Fidelity & Guaranty*, 273 Or 628, 636, 542 P2d 1031 (1975).

The first element of the *Chesterman* test is satisfied, because defendant acknowledges that Berry's conduct occurred at work. Defendant argues that Berry was not motivated to serve defendant when he sexually harassed plaintiff and was not hired to engage in that behavior. Defendant defines the issue under the three-part scope of employment analysis too narrowly. The *Restatement (Second) Agency*, 229(1) (1958) describes the type of conduct that is relevant to the three-part test:

> "To be within the scope of employment, conduct must be of the same general nature as that authorized, or incidental to the conduct authorized."

128 Or App 632> The *Restatement* also provides:

> "An act, although forbidden, or done in forbidden manner, may be within the scope of employment." *Restatement, supra*, at 230.

In *G.L. v. Kaiser Foundation Hospitals, Inc.*, 306 Or 54, 60, 757 P2d 1347 (1988), the Supreme Court quoted, with approval, section 245 of the *Restatement*, which provides:

> "A master is subject to liability for the intended tortious harm by a servant to the person or things of another by an act done in connection with the servant's employment, although the act was unauthorized, if the act was not unexpectable in view of the duties of the servant." Restatement, supra, at 245.

As the Ninth Circuit recently explained, in a diversity case involving Oregon law,

> "the specific egregious act giving rise to an intentional tort claim will itself rarely be 'of a kind which the employee was hired to perform;' the appropriate inquiry is whether the employee committed the tort while performing, or in connection with, his job responsibilities." *Dias v. Sky Chefs, Inc.*, 919 F2d 1370, 1375 (9th Cir 1990), *vacated on other grounds* 501 US 1201, 111 S Ct 2791, 115 L Ed 2d 965 (1991), *affirmed on remand* 948 F2d 532 (9th Cir 1991), *cert denied* ___ US ___, 112 S Ct 1294, 117 L Ed 2d 517 (1992).

In *Carlson v. Crater Lake Lumber Co., supra,* the plaintiff claimed wrongful discharge, alleging that her supervisor harassed her in retaliation for resisting his sexual harassment. 105 Or App at 316. Noting that the question of scope of employment is generally one of fact, we concluded that a jury should be allowed to consider whether the supervisor's alleged harassment fell within the scope of his employment.

Defendant argues that this case is controlled by *G.L. v. Kaiser Foundation Hospitals, Inc., supra,* and *Carr v. U.S. West Direct Co.*, 98 Or App 30, 36, 779 P2d 154, *rev den* 308 Or 608 (1989), which held that the employees' acts of sexual assault could not reasonably be considered acts carried out for the benefit of the employer. Those cases are distinguishable, because they involved no allegation that the employer's agent acted with the intention of furthering the employer's business purposes.

128 Or App 633> In contrast, in this case, a factfinder could infer from the record that sexual harassment was a characteristic of Berry's method of supervising and controlling female subordinate employees in the workplace, and that defendant condoned this supervisory technique. Berry created a pervasive atmosphere of sexual harassment, was the subject of an earlier sexual harassment claim that the Bureau of Labor and Industry investigated, and was notorious within the company for discriminating against women. Despite the earlier complaint and his reputation, defendant retained Berry in a supervisory role. Berry told plaintiff that he harassed her because the male employees that he supervised expected that behavior. In a letter to the Employment Division after defendant fired him, Berry said that he "was discharged for something that my superiors condoned by participating in the same sort of conduct."[2] The evidence is sufficient to create a factual question regarding the second and third parts of the test described in *Chesterman v. Barmon, supra.* The court erred in dismissing plaintiff's claim for intentional infliction of emotional distress.

Plaintiff's claim for statutory discrimination under ORS 659.030[3] requires us to decide when an employer is responsible for sexual harassment on the job by a co-worker who is a supervisor. Both parties suggest a standard other **<128 Or App 633/634>** than the traditional "scope of employment"

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[2] Plaintiff submitted this letter in her response to defendant's motion for summary judgment, and defendant made no objection to that submission in the trial court. In the absence of an objection, the court may consider hearsay evidence offered in support of or opposition to a summary judgment motion. *Knez Building Materials Co. v. Manikas*, 113 Or App 220, 222 n 2, 831 P2d 80 (1992).

[3] ORS 659.030(1) provides, in part:

"[I]t is an unlawful employment practice:

"(a) For an employer, because of an individual's * * * sex, * * * to refuse to hire or employ or to bar or discharge from employment such individual. * * *

"(b) For an employer, because of an individual's * * * sex, * * * to discriminate against such individual in compensation or in terms, conditions or privileges of employment.

"* * * * *

"(f) For any employer * * * to discharge, expel or otherwise discriminate against any person because the person has opposed any practices forbidden by this section * * *."

Harassment that creates a hostile work environment can constitute unlawful discrimination. *See Holien v. Sears, Roebuck and Co.*, 298 Or 76, 90, 689 P2d 1292 (1984); *Swanson v. Eagle Crest Partners, Ltd.*, 105 Or App 506, 508, 805 P2d 727, *rev den* 311 Or 433 (1991).

analysis. Plaintiff argues that we should adopt a form of absolute employer liability for harassment by a supervisor. Defendant urges us to adopt the standard followed by the federal courts in sex discrimination cases under Title VII of the Civil Rights Act of 1964, as amended, 42 USC 2000e et seq, on which ORS 659.030 is based.[4] *See Seitz v. Albina Human Resources Center*, 100 Or App 665, 673, 788 P2d 1004 (1990).

The text and context of the statute do not disclose the legislature's intent. *See PGE v. Bureau of Labor & Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The legislative history is unenlightening, and the question is not answered by Oregon case law.

Because Title VII was the basis for ORS 659.030, the federal cases are instructive. *See Goldsborough v. Eagle Crest Partners, Ltd.*, 105 Or App 499, 503, 805 P2d 723 (1991), *aff'd* 314 Or 336, 838 P2d 1069 (1992). The federal courts acknowledge that sexual harassment may take different forms. Those courts generally follow two methodologies in analyzing such cases.[5] In "quid pro quo" cases, the employer is liable if it links employment benefits to the acceptance or rejection of sexual favors. *Karibian v. Columbia University*, 14 F3d 773 (2d Cir 1994). The employer is strictly liable if the supervisor uses the employee's acceptance or rejection of sexual favors as a quid pro quo for job benefits. *Steele v. Offshore Shipbuilding, Inc.*, 867 F2d 1311, 1316 (11th Cir), **<128 Or App 634/635>** *reh'g denied* 874 F2d 821 (1989). Plaintiff does not show that her claim constitutes quid pro quo sex discrimination.

The second methodology permits recovery for a sexually "hostile environment." *Meritor Savings Bank v. Vinson*, 477 US 57, 67, 106 S Ct 2399, 91 L Ed 2d 49 (1986), says:

> "For sexual harassment to be actionable, it must be sufficiently severe or pervasive 'to alter the conditions of [the victim's] employment and create an abusive working environment.'" (Quoting *Henson v. City of Dundee*, 682 F2d 897, 904 (11th Cir 1982).)

See also Harris v. Forklift Systems, Inc., ___ US ___, 114 S Ct 367, 126 L Ed 2d 295 (1993). In applying this methodology, the Court has not adopted a precise standard for determining an employer's liability for a supervisor's conduct, but has applied only general agency principles. *Meritor Savings Bank v. Vinson, supra*, 477 US at 72. However, the lower federal courts have developed a somewhat clearer rule. In *Steele v. Offshore Shipbuilding, Inc., supra*, 867 F2d at 1316, the court held that when the plaintiff claims that a co-worker created a hostile environment through sexual harassment, the employer is liable if the employer "knew or should have known of the harassment and failed to take prompt remedial action against the supervisor." *See also E.E.O.C. v. Hacienda Hotel*, 881 F2d 1504, 1516 (9th Cir 1989); *Brooms v. Regal Tube Co.*, 881 F2d 412, 421 (7th Cir 1989). The Oregon Supreme Court quoted this federal standard, without comment, in *Holien v. Sears, Roebuck and Co.*, 298 Or 76, 89, 689 P2d 1292 (1984). We follow that standard here.

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[4] 42 USC 2000e-2 provides, in part:

> "(a) **Employer practices**
>
> "It shall be an unlawful employment practice for an employer--
>
> "(1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." (Emphasis in original.)

[5] As noted in *Ellison v. Brady*, 924 F2d 872, 875 n 4 (9th Cir 1991),

> "Some courts have entertained causes of action for sexual harassment which do not fall squarely within the quid pro quo cases or the hostile environment cases. For example, some courts have classified harassment based on the victim's gender as sexual harassment where the conduct or language is not sexual in nature. *See, e.g., Hall v. Gus Construction Co.*, 842 F.2d 1010, 1014 (8th Cir. 1988). Our examples are illustrative and not exclusive because we realize that sexual harassment is a rapidly expanding area of the law."

Plaintiff's evidence, if credited, shows that Berry created a pervasive atmosphere of sexual harassment, that he was the subject of an earlier sexual harassment claim that the Bureau of Labor and Industry investigated, that he was notorious within the company and that defendant condoned the activity. There is a genuine issue of material fact as to whether management-level employees of defendant had reason to know of Berry's conduct and condoned it. There is also a genuine issue of material fact as to whether the corrective action that defendant took was sufficiently "prompt." Accordingly, we conclude that the court erred in dismissing plaintiff's claim that she suffered "hostile environment" **<128 Or App 635/636>** discrimination through Berry's actions, and that defendant is responsible for those actions.

Reversed and remanded on claims for intentional infliction of emotional distress and statutory sexual discrimination; otherwise affirmed.

Cite as 128 Or App 692 (1994) June 29, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Tamara Sigler, Claimant.

TAMARA **SIGLER**, Petitioner,
v.
A & B AUTOMOTIVE and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(91-14416; CA A80712)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 20, 1994.
Scott Lumsden argued the cause for petitioner. On the brief was Michael R. Dehner.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Rossman, Presiding Judge, and Richardson, Chief Judge, and Leeson, Judge
PER CURIAM
Reversed and remanded for reconsideration.

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128 Or App 693> Claimant seeks review of a Workers' Compensation Board order denying her compensation. The Board's determination that she failed to prove entitlement to an award of impairment is supported by substantial evidence. Claimant concedes that our recent decision in *Hathaway v. Health Future Enterprises*, 125 Or App 549, 865 P2d 503, *rev allowed* 319 Or 80 (1994), requires that we reject her third assignment of error. The only remaining question is whether the Board erred in declining to consider a medical report claimant submitted after issuance of an order on reconsideration. We conclude that it did and reverse.

In December, 1990, claimant injured her neck in a work-related automobile accident. The claim was closed on May 15, 1991, with no award for permanent partial disability. An October 15, 1991, order on reconsideration affirmed. Claimant requested a hearing, at which she submitted a medical report prepared on December 31, 1991. The referee affirmed the order. On appeal, the Board, relying on ORS 656.268(7), refused to consider the December 31, 1991, medical report.

We have held that there is no limitation on a claimant's right to submit evidence at hearing. ORS 656.283(7); *Scheller v. Holly House*, 125 Or App 454, 457, 865 P2d 475 (1993), *rev den* 319 Or 36 (1994); *Safeway Stores, Inc. v. Smith*, 122 Or App 160, 163, 857 P2d 187 (1993). The Board erred in refusing to consider the December 31, 1991, medical report.[1]

Reversed and remanded for reconsideration.

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[1] No medical arbiter was appointed; the only question involves whether the evidence is admissible under ORS 656.283(7).

Cite as 129 Or App 1 (1994) July 6, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Valorie L. Leslie, Claimant.

VALORIE L. **LESLIE**, Petitioner,
v.
US BANCORP, Respondent.
(WCB 92-02861; CA A80200)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 16, 1994.
Donald Hooton argued the cause for petitioner. On the brief was Michael R. Dehner.
William H. Walters argued the cause for respondent. With him on the brief were Brian B. Doherty and Miller, Nash, Wiener, Hager & Carlsen.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Reversed and remanded for reconsideration of award of permanent disability; otherwise affirmed.

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129 Or App 3> Claimant seeks review of an order of the Workers' Compensation Board that denied her compensation. We affirm in part and reverse and remand in part.[1]

Claimant compensably injured her shoulder. After treatment, she returned to light duty work. Later, employer issued a notice of closure that awarded her unscheduled disability and temporary disability benefits. Claimant asked for reconsideration of the notice of closure. The Department of Insurance and Finance (DIF)[2] increased claimant's unscheduled disability and awarded her additional temporary disability benefits. Claimant requested a hearing, asserting that she was entitled to scheduled disability and an increase in unscheduled disability, and that employer had failed to pay the temporary disability benefits awarded on reconsideration. The Board increased claimant's unscheduled disability, but found that no temporary disability benefits were due. It also concluded that, because claimant had not advanced the issue of scheduled disability on reconsideration before DIF, she was precluded from raising it at the hearing before the referee.

Claimant's first assignment of error is directed at the Board's conclusion that she was not entitled to additional temporary disability benefits. Employer paid temporary disability benefits up to the time claimant was released to full time, modified work. The evidence shows that when claimant returned to work, she worked at a new position that paid higher wages than she was earning before her injury.[3] Although there is some evidence that claimant initially worked part time, there is no evidence that, after returning to **<129 Or App 3/4>** work, she lost wages because of her injury. Because there is no evidence that claimant lost wages as a result of her injury during the period for which she seeks compensation, the Board did not err in failing to award her additional temporary disability benefits. *See Safeway Stores v. Owsley*, 91 Or App 475, 756 P2d 48 (1988).

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[1] Employer asks that we strike claimant's brief, because it does not adequately identify the applicable standards of review. Because the applicable standard of review is discernable from the context of claimant's arguments, we exercise our discretion to consider the assignments of error identified in claimant's brief. *See State v. Burghart*, 120 Or App 408, 852 P2d 922 (1993); *State v. Alvord*, 118 Or App 111, 846 P2d 432 (1993).

[2] That department since has been renamed the Department of Consumer and Business Services. We will refer to the department as DIF, because that was its name at the time it issued the order in this case.

[3] At oral argument, counsel for claimant contended that, because claimant initially worked part time, her actual earnings were less than they were before the injury. There is no evidence in the record that supports that argument.

Claimant's next assignment is that the Board erred in not awarding attorney fees for "prevailing at hearing over [employer's] cross-appeal of the temporary disability award." The Board found that employer did not cross-appeal on claimant's entitlement to those benefits.[4] Substantial evidence supports that finding. Claimant was not entitled to prevailing party attorney fees. ORS 656.382(2).

Claimant's third assignment is that the Board erred in concluding that she could not raise the issue of whether she was entitled to scheduled permanent disability, because she did not first present that issue on reconsideration before DIF. In reaching that conclusion, the Board relied on its decision in *Raymond L. Mackey*, 45 Van Natta 776 (1993),[5] in which it held that a claimant is required by statute to first present an issue to DIF on reconsideration before the issue may be raised at hearing. Claimant contends that the Board has the authority to "review * * * all issues that were or could have been reconsidered by [DIF]," and that the Board's decision "contravenes" ORS 656.283(7). Employer argues that ORS 656.268(4)(e) and ORS 656.283(7), on which the Board relied, precludes claimant from asserting her right to scheduled disability.

ORS 656.268(4)(e) provides that, "if a worker objects to the notice of closure, the worker must first request reconsideration * * *." Even assuming that ORS 656.268(4)(e) requires a party to raise all possible objections to a notice of closure on reconsideration before DIF, it is silent about what issues can be raised at hearing.

129 Or App 5> ORS 656.283(7) does not support employer's argument. It provides, in part:

> "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing * * *."

That language provides authority for the referee to consider *evidence* that could not have been submitted to DIF on reconsideration. *See Safeway Stores, Inc. v. Smith*, 122 Or App 160, 857 P2d 187 (1993). It is silent about whether a party may raise issues at hearing that the party failed to present on reconsideration under ORS 656.268(4)(e). Employer provides no other authority in ORS chapter 656 or the administrative rules, and we have found none, that would preclude claimant from raising an issue at hearing that was not raised before DIF on reconsideration. We conclude that neither ORS 656.268(4)(e) nor ORS 656.283(7) precludes a claimant from raising an issue for the first time at hearing.[6] Claimant should have been allowed to raise her entitlement to scheduled permanent disability before the referee.

Claimant's fourth assignment is that the Board erred in finding that her disability should be rated as of the date of the notice of closure. Employer concedes that claimant is correct, and we accept that concession. *See Safeway Stores v. Smith, supra.*

Claimant's final assignment is that the Board erred in refusing to remand the issue of her entitlement to unscheduled disability to the director of DIF for promulgation of temporary rules amending the rating standard. The Board, relying on its decision in *Gary D. Gallino*, 44 Van Natta 2506 (1992), said that the director has the exclusive authority to make findings about whether a worker's disability is addressed by the ratings standards and held that it was without authority to remand. We have since held that the Board has the authority to review the director's application of existing rating standards and to remand in appropriate circumstances. *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 541, 836 P2d 530 (1993).

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[4] Although employer did not specifically cross-appeal claimant's entitlement to additional temporary disability benefits, it did question whether any additional temporary disability benefits were due. The Board found that claimant was entitled to "an award of temporary partial disability equal to zero."

[5] The petition for judicial review in Mackey is pending before this court. *Mackey v. Dow Corning, Inc.* (CA A79594).

[6] We need not decide whether the Board has the discretion to require that a claimant must, before raising an issue at hearing, present that issue on reconsideration before DIF.

129 Or App 6> Employer argues that, notwithstanding our decision in *Gallino*, we should affirm on this assignment, because the referee concluded that claimant had not presented evidence that would support a request to remand this matter for promulgation of a temporary rating rule. In light of the Board's statement that the director has the exclusive authority to make findings about whether a worker's disability is addressed by the ratings standards, we cannot tell if the Board considered whether or not the referee's conclusion was correct.

Reversed and remanded for reconsideration of award of permanent disability; otherwise affirmed.

Cite as 129 Or App 13 (1994) July 6, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Pete E. Haney, Claimant.

PETE E. **HANEY**, Petitioner,
v.
UNION FOREST PRODUCTS, MECHANICAL FABRICATORS, INC., and SAIF CORPORATION,
Respondents.
(89-05193, 89-07725, 89-05194; CA A74342)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 21, 1992.
Karen M. Werner argued the cause for petitioner. With her on the brief was Bettis & Associates.
Pamela A. Schultz argued the cause for respondent Union Forest Products. With her on the brief was Schultz & Taylor.
Garry L. Reynolds argued the cause for respondent Mechanical Fabricators, Inc. With him on the brief was Reynolds & Bendixsen, P.C.
Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.
Before Richardson, Chief Judge, and Deits and Riggs,* Judges.
DEITS, J.
Affirmed.
*Riggs, J., *vice* Durham, J.

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129 Or App 15> Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's denial of benefits on the basis of its finding that at the time of the injury, claimant was working temporarily in Oregon for a Washington employer and, therefore, was not an Oregon subject worker. We affirm.

Claimant sustained a low back injury in 1987 while working in Oregon for Union Forest Products (UFP). At that time, he missed less than three days of work, and the injury was accepted as nondisabling. However, he continued to experience low back pain and a "bruised" sensation in that area. In November, 1988, claimant began to work at an Oregon work site for Mechanical Fabricators, Inc. (MFI), a Washington corporation. After two weeks of work for MFI, claimant began to experience pain in his right buttock and down his right leg, and on December 22, 1988, he stopped working. He was diagnosed with a large disc herniation and, on April 24, 1989, received a laminectomy and discectomy. Claimant filed a claim with UFP, which denied responsibility, and with MFI, which denied the claim on the ground that it was not properly brought in Oregon. SAIF, as the processing agent for claims against employers not insured or self-insured for workers' compensation claims in Oregon, also denied the claim on behalf of MFI on the basis that claimant was not a subject Oregon worker and MFI was not a subject Oregon employer. Claimant also filed a claim against MFI with Washington State's Department of Labor and Industries, which denied the claim on the ground that claimant was an Oregon worker and not covered by Washington's Industrial Insurance Law.

The Board found that claimant sustained a new injury to his low back while employed by MFI. However, because the Board concluded that claimant was temporarily working in Oregon and was not an Oregon subject worker, it concluded that under ORS 656.126, he was not entitled to benefits under Oregon Workers' Compensation Law.

ORS 656.027 provides that "[a]ll workers are subject to [the Workers' Compensation Law] except those nonsubject **<129 Or App 15/16>** workers described in the following subsections[.]"[1] Claimant does not qualify as a nonsubject worker under any of the exclusions. However, a worker may be exempted from the Oregon Workers' Compensation Law by application of the extraterritorial provisions in ORS 656.126. At the time of claimant's injury, those provisions stated:

> "Any worker from another state and the employer of the worker in that other state are exempted from the provisions of [this chapter] *while that worker is temporarily within this state* doing work for the employer:
>
> "(a) If that employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of a state other than Oregon so as to cover that worker's employment while in this state;
>
> "(b) If the extraterritorial provisions of [this chapter] are recognized in that other state; and
>
> "(c) If employers and workers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state." ORS 656.126(2).[2] (Emphasis supplied.)

Claimant contends that the Board erred in concluding that he came within ORS 656.126(2) and therefore was not covered by Oregon's Workers' Compensation Law. It is his position that he is an Oregon subject worker. Claimant first contends that the Board's conclusion was wrong because the evidence shows that he was not a worker from another state working temporarily in Oregon at the time of his injury. He argues that the Board's findings on that point are not **<129 Or App 16/17>** supported by substantial evidence and that its legal conclusion is in error.

In determining whether a worker is temporarily within the state, the permanent employment relation test must be applied. *Northwest Greentree, Inc. v. Cervantes-Ochoa*, 113 Or App 186, 830 P2d 627 (1992); *Phelan v. H.S.C. Logging, Inc.*, 84 Or App 632, 735 P2d 22, *rev den* 303 Or 590 (1987). In applying that test,

> "no one factor controls; rather all of the circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding the claimant's work assignment, the state laws and regulations that the employer otherwise is subject to and the residence of the employees." *Northwest Greentree, Inc. v. Cervantes-Ochoa, supra*, 113 Or App at 189.

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[1] "Subject employer" is defined in ORS 656.023:

> "Every employer employing one or more subject workers in the state is subject to this chapter."

[2] ORS 656.126(2) was amended by Oregon Laws 1989, chapter 684, section 1, to provide:

> "Any worker from another state and the employer of the worker in that other state are exempted from the provisions of this chapter while the employer has a temporary workplace within this state and the worker is within this state doing work for the employer[.]"

In addition, ORS 656.026(6) was added to the statute in 1989:

> "For the purpose of this section, 'temporary workplace' does not include a single location within this state where the employer's work is performed by one or more workers for more than 30 days in a calendar year."

Those amendments were not in effect at the time of claimant's injury and, therefore, they do not apply to claimant.

The Board found that MFI is a Washington corporation with its corporate office in Spokane, Washington, and that most of MFI's work is performed in Washington. It found that MFI had no office in Oregon, that it paid its workers with checks issued from a Washington bank, that it deducted Oregon income taxes for claimant, and paid unemployment insurance for claimant in Oregon. In addition, it found that claimant was hired in Oregon with approval from the president of MFI in Washington, and that claimant was hired with the intent that he would be a permanent employee if MFI was pleased with the quality of his work. MFI was pleased with the quality of claimant's work. The Board also found that MFI rarely hires temporary workers, and that if claimant had not been injured he would have been offered available work. The Board found that claimant "would have accepted work outside Oregon as an alternative to unemployment in Oregon." The Board's findings are supported by substantial evidence. Further, we agree with the Board's conclusion, based on its findings, that under the permanent employment relation test, claimant was temporarily working in Oregon for a Washington employer. *See Phelan v. H.S.C. Logging, Inc., supra*, 84 Or App at 635.

Claimant also argues, however, that MFI is only entitled to the exemption under ORS 656.126(2) if subsections (a) through (c), quoted above, are satisfied. Claimant **<129 Or App 17/18>** specifically argues that subsection (a) of ORS 656.126(2) is not satisfied. Subsection (a) provides that the employer must have furnished

> "workers' compensation coverage under the workers' compensation insurance or similar laws of a state other than Oregon so as to cover that worker's employment while in this state[.]"

The Board found that

> "MFI has workers' compensation insurance through the [S]tate of Washington. During the [Oregon] job MFI had a certificate of insurance from Washington issued to Oregon in accordance with the reciprocity agreement between the two states."

The Board further explained:

> "None of the parties to this case argue that the workers' compensation law of the [S]tate of Washington should not be applied to this case because of any deficiency in application of the extraterritorial provisions of either state. Because Washington meets the extraterritoriality requirements, [we] conclude that such an argument would not be accepted in any event. *See Bowers v. Mathis*, 280 Or 367, [571 P2d 489] (1977). [We] therefore have considered the evidence in view of ORS 656.126(2). [We] conclude that this case must turn upon whether claimant's employment in Oregon was temporary, as [we] conclude that MFI is a Washington employer."

We agree with the Board's conclusion that there were not any deficiencies in the extraterritorial provisions in either state. In a letter to MFI acknowledging that a certificate of Workers' Compensation Insurance had been issued to the State of Oregon, Washington's Department of Labor and Industries said:

> "This certificate will verify that your regularly employed Washington workers are under the jurisdiction of the Washington Industrial Insurance Act and entitled to the benefits of that Act while temporarily working in that state."

Claimant argues that the reciprocity requirements are not met, because his claim was not allowed at the initial stage in the Washington compensation system and, therefore, ORS 656.126(2)(a) was not satisfied because the employer did not provide coverage for him while in Oregon. When claimant **<129 Or App 18/19>** applied for benefits in Washington, its Department of Labor and Industries denied the claim, saying:

> "The claimant was an Oregon worker at the time of injury and is not covered under the industrial insurance laws of the State of Washington."

Claimant contends that because he has not been treated as a subject worker in Washington, ORS 656.126(2)(a) has not been satisfied. The problem with claimant's argument is that the law does not require Oregon, through its workers' compensation system, to assume coverage for a worker who, based on Oregon's findings and conclusions of law, is a worker of that other state simply because the other state does not grant coverage. Oregon, through its Workers' Compensation Board, properly found

that the extraterritorial provisions were satisfied and that claimant was temporarily working in Oregon and was not an Oregon subject worker. Those conclusions are correct. There is no provision in Oregon law that allows or requires that the decision of Oregon's Workers' Compensation Board be altered based on the outcome of a claim in another state.

Claimant also assigns error to the Board's conclusion that he sustained a new injury at MFI and, therefore, that the Oregon employer, UFP, was not responsible for the claim. The Board's findings are supported by substantial evidence and its conclusion follows from those findings.

Affirmed.

Cite as 129 Or App 62 (1994) July 6, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LANCE J. **CADDY** and JANET E. CADDY, Appellants,
v.
DAVID A. **SMITH**, Respondent.
(CV92-0100; CA A78258)

Appeal from Circuit Court, Benton County.
Robert S. Gardner, Judge.
Argued and submitted October 4, 1993.
Patrick L. Hadlock argued the cause for appellants. With him on the brief were Larry W. Stuber and Ringo & Stuber, P.C.
J. Philip Parks argued the cause for respondent. With him on the brief were Billy M. Sime and Parks, Bauer & Sime.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Reversed and remanded.

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129 Or App 64> Plaintiffs appeal a summary judgment granted in favor of defendant on their claim that defendant negligently failed to procure a policy of insurance for them. We reverse and remand.

We view the facts from the record on summary judgment in the light most favorable to plaintiffs, the nonmoving parties. *Gaston v. Parsons*, 318 Or 247, 251, 864 P2d 1319 (1994).

Plaintiffs were building their own home. Defendant is an insurance agent. Plaintiff Lance Caddy spoke to an employee of defendant's about obtaining insurance coverage for potential liability related to the construction of the house. According to Lance:

> "I told her that I need some insurance, and she said okay. And I said I need the usual kinds of things in case it burns to the ground, in case this and that in various stages of construction and there are two specific things I want covered. And she said okay. And I said, 'There are a lot of people wandering in and out of my house, sight-seers, lookers-on, et cetera, and in case one of those people falls down, since there are no lights, et cetera, and breaks his neck, I want that taken care of.' She said okay. I said, 'There are a lot of people wandering out there working on the job and I don't want any liability as far as any of those people are concerned.' And she said, 'Well, I'll have to ask you a couple of questions.' I said 'Okay.' She said, 'Who's the contractor?' I said, 'Well, I don't know.' She said, 'Well, who's building it for you?' And so I gave her the name of the person who was the hammer and saw man. And she said, 'But is he the contractor?' And I said, 'No.' She said, 'Well, are you the contractor?' And I said, 'Well, I don't know.' And she said, 'Well, who's paying the bills?' And I said, 'Well, I am.' And she said, 'Well, are there subcontractors on the job?' I said, 'Yes.' She said 'Are they insured?' And I said, 'There are a lot of people out there. I really don't know who's insured and who is not.' She said 'Okay.'

> "And then she said, 'Well, I have to ask a couple of other questions.' So she asked me questions about how big the house was and what its construction was and was it frame or brick, and did it have a fireplace and did it have deadbolts, was it going to have deadbolts on the doors, and did it have a fire alarm system, et cetera, et cetera. And I answered those **<129 Or App 64/65>** questions. And she said, 'Okay, I'll take care of it for you.' And I said 'Okay. Thanks. Let me know how much it is and I'll drop by a check.'"

Defendant procured a standard homeowner's policy for plaintiffs. That policy excluded workers' compensation coverage. Defendant did not discuss the exclusion with plaintiffs. At the time, defendant did not sell workers' compensation coverage, although he had in the past. Defendant advised his employees to tell people who wanted workers' compensation insurance to contact the State Accident Insurance Fund (SAIF). Plaintiffs were not told that.

During construction on the house, a worker was injured. Plaintiffs did not have workers' compensation insurance. The Workers' Compensation Board held that the injured worker was plaintiffs' employee and that plaintiffs were noncomplying employers who were responsible for paying for the injuries, and we affirmed. *Caddy v. SAIF*, 110 Or App 353, 822 P2d 156 (1991).

Plaintiffs then brought this action, alleging that defendant was negligent in failing to obtain workers' compensation coverage for them and in failing to inform them that they needed workers' compensation coverage.[1] Defendant moved for summary judgment. The trial court granted the motion, and entered judgment for defendant. Plaintiffs appeal, assigning error to the trial court's order granting defendant's summary judgment motion.

Summary judgment is appropriate when no issue of material fact exists and the moving party is entitled to judgment as a matter of law. *Gaston v. Parsons, supra*, 318 Or at 251.

Plaintiffs argue that there are issues of material fact as to whether defendant was negligent in failing to procure workers' compensation coverage and in failing to advise them of their need for that coverage. Defendant argues that the evidence is insufficient to raise a jury question on both **<129 Or App 65/66>** specifications of negligence, because it is undisputed that plaintiffs never asked defendant to obtain workers' compensation insurance and, without such a request, defendant had neither a duty to procure that insurance nor a duty to advise plaintiffs of the need for that insurance.

First, we address plaintiffs' allegation that defendant negligently failed to procure workers' compensation insurance. Insurance agents owe their insureds a duty of reasonable skill and care in carrying out the insureds' instructions. *Kabban v. Mackin*, 104 Or App 422, 434, 801 P2d 883 (1990). Depending on the nature of the instructions, that duty may include an obligation to procure insurance. As the Supreme Court said in *Joseph Forest Products v. Pratt*, 278 Or 477, 564 P2d 1027 (1977):

> "An insurance agent or broker who agrees procure insurance for another for a fee but fails to do so may be liable for any damage resulting from his omission. Liability may be based upon a breach of contract or upon negligence, or upon both, depending on the particular circumstances of the case." 278 Or at 480.

Defendant does not take issue with that statement of the law, but argues that there is no basis for concluding that plaintiffs ever asked him to procure workers' compensation insurance. We disagree. Plaintiff specifically said that he wanted insurance to cover "any liability" for those who were "working on the job" at the house. Defendant's employee then asked a number of questions about whether plaintiff was the contractor and whether the workers had their own insurance, and then assured plaintiff that defendant would take care of that request. That testimony, viewed in the light most favorable to plaintiffs, reasonably supports a finding that plaintiffs provided sufficient information to defendant to give rise to a duty to procure workers' compensation insurance.

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[1] Plaintiffs also alleged that defendant was negligent in failing to tell them to consult with an attorney about whether they needed workers' compensation coverage, in failing to consult with an attorney about plaintiffs' need for workers' compensation coverage and in authorizing an employee to sell insurance without a license. Those allegations of negligence, however, are not at issue on appeal.

We address plaintiffs' allegation that defendant negligently failed to advise them of their need to procure workers' compensation insurance. When an insurance agent agrees to procure insurance for an insured, the agent undertakes a duty to explain the extent to which the insurance procured actually provides the coverage that was requested. *Precision Castparts v. Johnson*, 44 Or App 739, 742-43, 607 P2d 763 (1980); *Larson v. Transamerica Life*, 41 Or App 311, 318-19, **<129 Or App 66/67>** 597 P2d 1292 (1979). Defendant argues that the duty to advise did not arise in this case, as a matter of law, because plaintiffs never provided sufficient information to constitute a request for workers' compensation insurance, much less that defendant agreed to provide it. As we have already held, however, the evidence reasonably supports a finding that defendant agreed to "take care of" plaintiffs' request for workers' compensation coverage. Under the circumstances, we cannot say that, as a matter of law, defendant did not have a duty to explain that the insurance it procured for plaintiffs did not include workers' compensation coverage.

The trial court erred in granting defendant's motion for summary judgment.

Reversed and remanded.

Cite as 129 Or App 73 (1994) July 6, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON COUNTRY FAIR, Petitioner,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents.
(91-03-010; CA A75377)

Judicial Review from Department of Insurance and Finance.

Argued and submitted April 21, 1993.

Russell D. Poppe argued the cause for petitioner. With him on the briefs were Lori R. Waldrop and Speer, Jones, Poppe & Wolf.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.

Leary C. Jones waived appearance for respondent National Council on Compensation Insurance.

Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.

HASELTON, J.

Reversed as to premium charged on the value of food vouchers; otherwise affirmed.

*Haselton, J., *vice* Durham, J.

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129 Or App 75> Oregon Country Fair (Fair) seeks review of a Department of Insurance and Finance (DIF)[1] final order requiring it to pay workers' compensation premiums to its carrier, SAIF Corporation, for two audit periods, covering February 1, 1987 through March 31, 1990. In particular, the Fair challenges DIF's determination that SAIF properly assessed premiums against the Fair's disbursement of vouchers for food and services and per diem payments to individuals providing services associated with the Fair. We reverse in part and affirm in part.

The Fair is a nonprofit, tax exempt, charitable corporation that conducts a three-day fair during the second weekend of July each year. Approximately 30,000 people attended the fair in each of the audit years. In 1989, the Fair hired two regularly paid workers, a caretaker and general manager. It otherwise operated on "volunteer"[2] services.

There were two categories of volunteers. First, a "core group" of about 20 volunteers helped prepare the fair site for one month before the fair, and helped restore the site to its original condition for one week after the fair. Second, approximately 700 to 1000 volunteers (the "three-day volunteers") assisted during the three days of the fair, performing such tasks as directing traffic, staffing information booths, and transporting water.[3]

Members of the core group received a "per diem" payment of up to $25 per day for each day they worked before and after the fair, but not during the fair. Although the per diem payments were budgeted in advance, the actual disbursal of this money depended on the Fair's gate receipts and were distributed at the discretion of crew coordinators. In **<129 Or App 75/76>** addition to per diems, core group volunteers received free meals and campsites.

The three-day volunteers received vouchers which were intended to be exchanged for food or showers, but which could also be redeemed for cash at the end of the fair. A volunteer could receive one voucher, worth $2, for every hour worked, up to a maximum of eight vouchers per day. Distribution of vouchers was contingent on an ongoing projection of sufficient gate proceeds and, like the per diems, the vouchers were issued at the discretion of crew coordinators.

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[1] DIF is now known as the Department of Consumer and Business Services. *See* ORS 656.005(9).

[2] We use the term "volunteer" as shorthand to describe persons providing services to the Fair, regardless of whether such services were gratuitous or were, as amplified below, provided pursuant to a contract of hire.

[3] The three-day volunteers represented a wide range of occupations, *e.g.*, woodworkers, attorneys, carpenters, and landscapers. Core group volunteers might also serve as three-day volunteers.

In 1990, SAIF conducted a premium audit of the Fair. SAIF concluded that the vouchers and per diems were paid to "subject workers" within the meaning of *former* ORS 656.005(27)[4] and were, thus, subject to accounting for purposes of premium assessment, yielding an additional premium assessment of $5,252. The Fair appealed, and DIF upheld the premium assessment on the ground that the individuals providing services to petitioner were subject workers.

The Fair argues that DIF erred in upholding SAIF's premium assessment for two reasons. First, neither the core group volunteers nor the three-day volunteers were "workers" under *former* ORS 656.005(27) because the Fair had no contract for remuneration with the volunteers and the volunteers were not subject to the Fair's direction and control. Second, the Fair argues that, even if the volunteers were "workers," they were exempt from workers' compensation coverage under ORS 656.027(10).[5] Because the analysis of these issues varies with respect to the core group volunteers and the three-day volunteers, we address each in turn.

129 Or App 77 >

Core Group Volunteers

Our analysis of the core group's receipt of per diem disbursements follows the methodology set out in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 872 P2d 1 (1994). Thus, we first consider whether DIF correctly concluded that the core group volunteers were "workers" under *former* ORS 656.005(27). If we sustain DIF's determination in that regard, we must then determine whether the core group volunteers fall within one of the statutory "nonsubject worker" exemptions, including ORS 656.027(10).

Former ORS 656.005(27) provided, in part:

> "'Worker' means any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *."

ORS 656.005(13) provides:

> "'Employer' means any person * * * who contracts to pay a remuneration for and secures the right to direct and control the services of any person."

The Fair argues that it had no contract with the core group volunteers because those volunteers had no legally enforceable entitlement to consideration for their services, specifically including the per diem payments. In particular, the Fair argues that there was no enforceable entitlement to per diems because the actual amount to be paid was undetermined and at the discretion of the crew coordinators.

DIF made the following finding:

> "If the crew coordinator's per diem requests were within the previously board-established budget, and the gate admissions were sufficient to cover the payments, the core group received the payments. If the crew coordinator's per diem requests exceeded the budget, or the gate admissions were insufficient to allow per diem payments, the fair coordinator denied the request. The core group workers knew that per diem payments were budgeted and that they would receive *some payment* if the petitioner's gate admissions were sufficient to allow disbursement of per diem payments." (Emphasis supplied.)

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[4] *Former* ORS 656.005(27) was renumbered ORS 656.005(28) in 1990. Or Laws 1990, ch 2, 3.

[5] In 1991 the legislature added ORS 656.027(19), which provides that a nonsubject worker is

> "[a] person performing services on a volunteer basis for a nonprofit, religious, charitable or relief organization, whether or not such person receives meals or lodging or nominal reimbursements or vouchers for meals, lodging or expenses."

That provision does not apply to the facts of this case, because it was enacted after the audit period.

Thus, DIF found that, if the Fair's gate proceeds were sufficient, per diems *would* be paid, although a specific amount **<129 Or App 77/78>** was not guaranteed. That finding was supported by substantial evidence. ORS 656.298; ORS 183.482. In such circumstances, where "the expectation of pay is uncertain in the sense of being conditional on the prosperity of the enterprise[,]" there was a contract for hire between the Fair and the core group volunteers. 1B Larson, *Workmen's Compensation Law* 8-372, 47.42(a) (1993).

Because there was a contract of hire, core group members were "workers" under *former* ORS 656.005(27), if they were subject to the Fair's direction and control. Four factors are material in determining whether an employer has the right to control an individual:

> "(1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire." *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989).

If that inquiry is inconclusive, worker status is determined by reference to the "relative nature of the work" test. *See Woody v. Waibel*, 276 Or 189, 197, 554 P2d 492 (1976).

In concluding that the Fair had the right to control all of the volunteers, including the core group, DIF discussed the Fair's supervision of volunteers' activities consonant with the purposes of the fair. In particular, it found that the Fair developed plans to "coincide with its goals as stated in the by-laws" and organized various "work groups" that met throughout the year to carry out the plans. DIF concluded:

> "While latitude is granted to individuals in carrying out [the plans], the overall goals and aims of the fair dictate the overall result. The petitioner might not concern itself with a particular individual's style of dress or manner of work, but the details of the work has [sic] been agreed upon and developed well before the commencement of the fair."

In these circumstances, the Fair's substantial supervision of the details of the volunteers' work was sufficient, by itself, to satisfy the "right to control" inquiry. *Accord* 1B Larson, *supra*, at 8-90 ("for the most part, any single factor is not merely indicative of, but, in practice, virtually proof of, the employment relation * * *"). Thus, DIF correctly concluded that the Fair had direction and control of the core group workers.

129 Or App 79> Having affirmed DIF's conclusion that core group members were "workers" for purposes of *former* ORS 656.005(27), we next consider whether they qualify for exemption under ORS 656.027(10). ORS 656.027(10) exempts from the definition of "subject worker":

> "A person performing services primarily for board and lodging received from any religious, charitable or relief organization."[6]

Under the exemption's "primarily" language, the value of the board and lodging workers receive must exceed the value of any other consideration received (here, the per diems). Otherwise, services are not performed "primarily" for food and lodging. Here, the Fair does not argue that the per diems were for food and lodging. Nor does the Fair argue that the value of the three free meals a day and the free campsite core group workers received was greater than the value of the per diems.

The Fair does, however, argue that the per diems are expense reimbursements and further argues that we should construe the exemption's "primarily" language to encompass expense reimbursements. We need not address that question of statutory construction because, even if we were to adopt the Fair's reading, the Fair presented no evidence that the amount of the per diems was in any way related to the core group's actual or estimated expenses. Indeed, DIF found that

> "the per diem was disbursed to workers based on the budget of the crew coordinator and the sufficiency of the gate admissions, and not based on a workers' actual food or lodging expenses."

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[6] It is undisputed on appeal that the Fair is a charitable organization.

The core group volunteers are not exempt under ORS 656.027(10). Petitioner's remaining assignments of error pertaining to the "core group" do not merit discussion. DIF did not err in upholding SAIF's additional premium assessment against the value of the per diems paid.

Three-Day Volunteers

We need not address the Fair's arguments that the three-day volunteers were not "workers" under *former* ORS **<129 Or App 79/80>** 656.005(27) because we conclude that even if those volunteers were "workers," they were exempt under ORS 656.027(10).[7] As noted, ORS 656.027(10) exempts from coverage "a person performing services primarily for board and lodging * * *."

DIF concluded that the exemption was inapplicable because the vouchers could be exchanged for cash. In particular, DIF concluded that, notwithstanding its finding that "the majority of individuals used their vouchers in trade for food or showers," ORS 656.027(10) required an *individualized*, and not a generalized, determination of the use of the food vouchers. DIF reasoned that, because the Fair did not specifically identify which of the hundreds of three-day volunteers actually used the vouchers for food or showers and because individuals could, and did, exchange vouchers for cash, the vouchers were not "primarily" for board and lodging. We reject that analysis which ignores the predominant purpose and use of the vouchers.

By distributing vouchers, the Fair intended to provide its volunteers with food and showers. Typically, volunteers received four vouchers per day, which provided them with $8 for meals and a shower. The uncontroverted evidence before DIF showed that an average meal at the fair cost from $4 to $7, and that a shower cost $2. Consequently, the vouchers approximated and, if anything, were insufficient to cover, the actual cost of food and lodging at the fair. Nothing in the administrative record suggests that the Fair used vouchers as a subterfuge for cash payments. Moreover, unlike the core group, three-day volunteers received no additional cash consideration for their services. Thus, as a class, the three-day volunteers performed their "services primarily for board and lodging" in the form of the vouchers.

DIF's preoccupation with the potential for individual voucher/cash exchanges is misplaced. This case arises in the **<129 Or App 80/81>** context of a premium audit. SAIF assessed a premium based on the Fair's total expenditures for vouchers; SAIF's audit did not involve an individualized determination. The fact that any given individual could have redeemed some or all of his or her food vouchers for cash does not alter the fundamental and dispositive fact that "the majority of [three-day volunteers] used their vouchers * * * for food and showers." In this generic premium audit context, that generalized determination is sufficient. DIF's order sustaining SAIF's assessment of compensation premiums based on the value of the vouchers was error.

Reversed as to premium charged on the value of food vouchers; otherwise affirmed.

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[7] *S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra*, 318 Or at 630, counsels that the preferred methodology is to determine "whether one is a 'worker' before a determination is made as to whether that 'worker' is a 'nonsubject' worker pursuant to one of the exemptions * * *." Here, however, any discussion of the "contract for remuneration" and "right of control" elements of "worker" status would greatly, and ultimately needlessly, extend our analysis of the three-day volunteers.

Cite as 129 Or App 82 (1994) July 6, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John J. Rice, Claimant.

JOHN J. **RICE**, Petitioner,
v.
COLUMBIA STEEL CASTING and EBI COMPANIES, Respondents.
(90-14069, 90-12474; CA A76773)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 14, 1993.
Philip F. Schuster, II, argued the cause and filed the briefs for petitioner.
Howard R. Nielsen argued the cause and filed the brief for respondents.
Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.
HASELTON, J.
Reversed and remanded for reconsideration.
*Haselton, J., *vice* Durham, J.

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129 Or App 84> Claimant seeks review of an order of the Workers' Compensation Board denying the compensability of surgery that he had for a flail arch at L5-S1. We review for errors of law and substantial evidence, ORS 656.298(6); ORS 183.482(8), and remand for the Board to describe the basis of its disposition of claimant's law of the case and issue preclusion arguments.

Claimant suffers from a congenital back condition. In 1989, his condition worsened and the Board ordered employer to accept the claim for an occupational disease. *John J. Rice,* 42 Van Natta 2513 (1990), *aff'd without opinion Connecticut Indemnity v. SAIF,* 109 Or App 329, 820 P2d 470 (1991) (*Rice I*). The Board in *Rice I* found that "[t]here was no specific incident at work but claimant's low back condition worsened" during the spring of 1989 when he "was engaged in work heavier than usual." Claimant received compensable back surgery at L3-L4 and L4-L5 in October 1989. In April 1990, claimant's back problems worsened again. His treating physician, Dr. Nash, recommended additional surgery on the same area. Several other doctors advised that repeated surgery on the same area would not be helpful. The referee initially concluded that the surgery was not compensable because it was not reasonable and necessary.

Claimant obtained the surgery anyway. Nash found and repaired a "totally flail arch" at L5-S1, adjacent to the location of the earlier surgery. Following the surgery, the referee granted claimant's request to reconsider the original denial in the light of the L5-S1 condition discovered during the surgery. On reconsideration, the referee found that claimant's second surgery presented a compensable claim for medical services because the surgery was reasonable and necessary and was related to claimant's compensable condition. The referee relied on the opinion of Nash that

> "the patient's injuries from 1990 and specifically the one in 1989 (pratfall) resulted in a total decompensation of stability due to the spondylolysis at the L5-S1."

The pratfall to which Nash referred is an alleged work incident in April 1989, which claimant failed to mention to the physicians who examined him at that time.

129 Or App 85> Employer sought Board review, arguing that Nash's opinion was unreliable, in part because the presumed 1989 pratfall never occurred. The Board reversed the referee, concluding that claimant "has not carried his burden of proving that he suffered a compensable injury [*i.e.*, the pratfall] in April 1989." In so holding, the Board expressly rejected as not credible, Nash's opinion that the L5-S1 condition was related to claimant's compensable condition.

In an amended motion for reconsideration, claimant argued for the first time that the issues of the compensability of his L5-S1 condition and its relation to the April 1989 pratfall were resolved in his favor in *Rice I*. The Board's order on reconsideration does not refer to these law of the case and issue preclusion arguments.

On review, claimant again asserts his law of the case and issue preclusion arguments, contending that we are bound by the determinations in *Rice I*. Employer counters that claimant did not preserve those arguments by raising them for the first time on reconsideration because the Board has discretion not to consider new arguments at that stage. We do not reach either claimant's law of the case and issue preclusion arguments or employer's response because we are unable to determine the basis of the Board's disposition of those arguments.

In particular, we cannot tell whether the Board: (1) decided, as a matter of law, that it *could* not reach claimant's arguments when raised for the first time on reconsideration; (2) decided, as a discretionary matter, that it *should* not reach those arguments in that procedural context; or (3) reached the merits of claimant's arguments and rejected them without discussion. Which of these routes, or any other, the Board followed materially affects our consideration of the issues on review.[1] Accordingly, we reverse and remand for reconsideration.[2]

129 Or App 86> Reversed and remanded for reconsideration.

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[1] Our opinion does not imply that the Board must always explain its disposition of issues on reconsideration. However, in this case, where the law of the case and issue preclusion issues were raised for the first time on reconsideration, the Board's lack of explanation makes it impossible for us to know what we are actually reviewing.

[2] Claimant also argues that the Board's findings that he did not suffer a pratfall in April 1989 and that the *Rice I* surgery did not cause the L5-S1 condition are not supported by substantial evidence. Because of our remand and the primacy of the law of the case and issue preclusion issues, we do not reach that alternative argument.

Cite as 129 Or App 192 (1994) July 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of William R. Johnson, Claimant.

WILLIAM R. **JOHNSON**, Petitioner,
v.
RSG FOREST PRODUCTS and SAIF CORPORATION, Respondents.
(92-13505; CA A82001)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 2, 1994.
Edward J. Harri argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson, Jensen & Correll.
Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
HASELTON, J.
Affirmed.

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129 Or App 194> Claimant seeks review of an order of the Workers' Compensation Board denying recovery of temporary total disability benefits for the period during which claimant was incarcerated under a judgment of criminal conviction that was subsequently vacated as void. We affirm.

Claimant suffered compensable bilateral carpal tunnel syndrome in 1988. In August 1990, claimant's attending physician requested authorization to perform surgery on claimant's wrists. However, before the carrier, SAIF Corporation, could act on that request, claimant was convicted of a crime and imprisoned in the Oregon State Penitentiary on October 29, 1990. SAIF subsequently approved the requested surgeries, which were performed in early 1992, while claimant was still in prison. On August 21, 1992, the Marion County Circuit Court vacated claimant's criminal conviction, and he was released from custody on August 28, 1992. On September 29, 1992, claimant's attending physician declared his wrist condition to be medically stationary.

SAIF paid claimant temporary total disability benefits from the date of his request for surgery to the date of his incarceration (June 14, 1990, to October 29, 1990) and from the date of his release through the date his condition was medically stationary (August 29, 1992, to September 29, 1992). However, SAIF refused to pay such benefits for the period of claimant's incarceration (October 29, 1990, through August 28, 1992). Claimant requested a hearing, arguing that because his conviction was ultimately vacated, he was entitled to temporary total disability benefits for the period of his incarceration. The referee, relying on ORS 656.160(1), rejected that argument, and the Board affirmed.

ORS 656.160 provides:

> "(1) Notwithstanding any other provision of this chapter, an injured worker is not eligible to receive compensation under ORS 656.210 or 656.212 for periods of time during which the worker is *incarcerated for the commission of a crime.*
>
> **129 Or App 195>** "(2) As used in this section, an individual is not 'incarcerated' if the individual is on parole or work release status." (Emphasis supplied.)[1]

---

[1] ORS 656.210(1), pertaining to temporary total disability benefits, provides, in part:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser."

ORS 656.212, pertaining to temporary partial disability benefits, provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

The only issue before us is whether the emphasized language encompasses incarceration pursuant to a judgment of criminal conviction that is later vacated as void. The statutory construction "template" of *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993), defines our analysis.

We begin with the text of ORS 656.160(1). "[I]ncarcerated for the commission of a crime" is reasonably susceptible to at least two readings, one general and one specific. That language could, as SAIF argues, refer broadly to any criminal incarceration, including incarceration for the alleged commission of a crime, as opposed to various species of "civil incarceration" (*e.g.*, civil commitment). Conversely, that language could, as claimant argues, refer only to incarceration for the *actual* commission of a crime.

Statutory context is more revealing. ORS 656.160(1) must be construed with particular reference to ORS 656.160(2), which excepts from the definition of "incarcerated" persons those who are on parole or work release status. In tandem, ORS 656.160(1) and (2) most plausibly express a legislative policy that only those persons who are available to participate in the work force are eligible for temporary disability benefits. This contextual construction accords with the fundamental "wage-replacement" function of temporary partial disability and temporary total disability benefits. *See* **<129 Or App 195/196>** ORS 656.210; ORS 656.212; *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 298, 702 P2d 403 (1985).

Thus, offenders on parole and work release who are eligible to work and earn wages can receive temporary disability benefits. Other persons incarcerated in the criminal system cannot. Guilt or innocence is immaterial; the only consideration is work force availability.[2]

Our consideration of the interplay between ORS 656.160(1) and (2), while useful, is not conclusive. We note, particularly, that ORS chapter 656 includes no equivalent to ORS 656.160 for noncriminal incarcerations. This, in turn, raises some doubt about whether ORS 656.160 embodies the neutral "work force availability" policy posited above or, in fact, expresses a penal policy under which denial of benefits is a function of actual criminal culpability.

Because the legislature's intent is not clear from the text and context of ORS 656.160, we proceed to legislative history. ORS 656.160 was enacted in 1990 in response to *Forshee & Langley Logging v. Peckham*, 100 Or App 717, 788 P2d 487, *rev dismissed* 310 Or 122 (1990), in which we held that a workers' compensation claimant was entitled to continue receiving temporary total disability benefits during the period of his criminal incarceration.[3] During a meeting of the Special Joint Committee on Workers' Compensation, the following colloquy between Representative Kevin Mannix and Ed Redman of the Governor's Workers' Compensation Labor Management Advisory Committee occurred:

> "*Representative Mannix*: In regard to incarceration in section 50, you say an individual is not, well, he's not going to get time loss during the time that you're [*sic*] incarcerated for **<129 Or App 196/197>** the commission of a crime. Do you mean for a conviction of a crime?
>
> "*Mr. Redman*: No.
>
> "*Representative Mannix*: Or commission?
>
> "*Mr. Redman*: We mean for commission of a crime, not conviction.
>
> "*Representative Mannix*: So even pretrial detention when there hasn't been a conviction?

---

[2] Claimant's position that ORS 656.160(1) is preoccupied with actual commission of crimes presumes that the statutory restriction of benefits is punitive. ORS 656.160(2)'s exclusion of criminal offenders on probation or work release status is arguably inconsistent with such a penal purpose.

[3] In deciding *Forshee & Langley Logging v. Peckham, supra*, we noted the absence of controlling legislation:

> "It is the legislature's province to restrict the ability of incarcerated individuals to collect workers' compensation and, in some situations, it has done so. See ORS 655.515 [limiting compensation benefits available to inmates injured in authorized employment while committed to the custody of the Department of Corrections]. We decline employer's suggestion that we create additional exceptions that have no basis in the statute." 100 Or App at 721.

"*Mr. Redman*: Yes. Our thinking in this area is *time loss is to replace salary and income,* and if a person is in jail and they're being held for trial or whatever, they are unable to work, and they are unable to work because of their time in jail. They should not be paid time loss for that period." Tape recording, Interim Special Committee on Workers' Compensation (SB 1197), May 3, 1990, Tape 4, Side A at 194.

That discussion confirms what the statutory context implies. The legislature's intent in enacting ORS 656.160(1) was to deny temporary disability benefits to anyone who has been excluded from the work force by incarceration relating to a criminal proceeding.[4]

Claimant was so excluded. Consequently, although his conviction was ultimately vacated, claimant was "incarcerated" for purposes of ORS 656.160(1) and was not entitled to temporary total disability benefits for the period of his imprisonment.[5]

Affirmed.

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[4] Consistent with the legislative history, the Workers' Compensation Division has promulgated a rule defining "incarceration" as including both "pretrial detention" and "imprison[ment] following conviction for a crime." OAR 436-60-045(1)(a)(A), (B).

[5] Claimant argues that this result subverts the fundamental remedial purposes of the workers' compensation laws by denying benefits to the dependents of "wrongfully incarcerated" claimants. However, the same could be said of the dependents of "rightfully incarcerated" claimants; both groups are comprised of innocent third parties, who would presumably benefit from the receipt of "wage replacement" compensation.

Cite as 129 Or App 220 (1994) July 27, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

BOB WILKES FALLING, INC., Respondent,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, and SAIF CORPORATION, Petitioner.
(88-10-018; CA A77187)

Judicial Review from Department of Insurance and Finance.

Argued and submitted February 28, 1994.

David L. Runner, Assistant Attorney General, argued the cause for petitioner. With him on the briefs were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Martha C. Evans argued the cause for respondent. With her on the brief was Evans Harrison Pease.

Before Deits, Presiding Judge, Richardson, Chief Judge, and Riggs, Judge.

RICHARDSON, C.J.

Affirmed.

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129 Or App 222> SAIF Corporation seeks review of an order of the Department of Insurance and Finance (DIF)[1] that disallowed premiums for workers' compensation coverage that SAIF charged to Bob Wilkes Falling, Inc. (Wilkes) for two timber cutters associated with Wilkes.[2] SAIF argues that DIF erred in concluding that the timber cutters were nonsubject workers who were exempt from workers'

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[1] DIF is now known as the Department of Consumer and Business Services.

[2] This issue was originally before us in *Bob Wilkes Falling v. National Council on Comp. Ins.*, 108 Or App 453, 816 P2d 1172, *rev den* 312 Or 527 (1991). We remanded the case to DIF for reconsideration of the issue in the light of *Little Donkey Enterprises, Inc. v. SAIF*, 107 Or App 400, 812 P2d 25 (1991). DIF subsequently issued and withdrew several orders. SAIF seeks review of DIF's "Revised Order Upon Reconsideration," dated May 10, 1993, which supplements and reaffirms its "Order on Remand," dated May 1, 1992.

compensation coverage by Wilkes under ORS 656.027(7).[3] Because we conclude that the timber cutters were not "workers" and, therefore, not subject to workers' compensation coverage, we affirm.

The basic facts are undisputed. Wilkes is an Oregon corporation that contracts with lumber mills, property owners and private individuals to fell trees and cut them into log lengths. During the premium audit periods in question,[4] Wilkes asked Northwest Timber (NWT) and Lake Price Logging (LPL) to bid on cutting certain units of one of Wilkes' projects, the "Charlotte Sale." NWT and LPL were each operated by one individual. Wilkes accompanied NWT and LPL to the units and pointed out the boundaries of the areas to be cut. NWT and LPL negotiated a cutting price with Wilkes and entered into written contracts.

The contracts incorporated the terms of Wilkes' agreement with the mill, including the rate of pay, date of completion and specification of log lengths. The contracts specified that NWT and LPL were independent contractors and that they had "full control and direction of work to be performed." The contracts did not discuss termination rights. The agreements required that NWT and LPL perform **<129 Or App 222/223>** the job in a "good and workmanlike manner," and DIF found that Wilkes was entitled to withhold payment if the job was not properly completed. There were arbitration clauses to resolve disputes arising under the contracts and attorney fees provisions that allowed costs and attorney fees to the nondefaulting party in a proceeding to enforce the contract.

As per their contracts, NWT and LPL each worked according to their own methods, supplied their own equipment and set their own hours. They were paid by the thousand board feet of timber cut, on the same basis as Wilkes was paid by the mill, and were allowed to take draws against future payment. NWT and LPL worked among Wilkes' employees who also felled and cut timber. Wilkes' employees were paid on a different basis than NWT and LPL. The Charlotte Sale was the only job NWT and LPL performed for Wilkes.

On the basis of these facts, DIF concluded that NWT and LPL were "workers, exempt as sole proprietors and independent contractors" under ORS 656.027(7). SAIF contends that DIF's conclusion that NWT and LPL were workers is inconsistent with its determination that they were exempt as sole proprietors under that statute. Wilkes responds that DIF correctly determined that NWT and LPL were exempt as sole proprietors.[5] At issue is the correct application of ORS 656.027(7).

At the relevant time, ORS 656.027(7) provided:

> "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:
>
> "* * * * *
>
> "(7) Sole proprietors."

We begin by determining whether NWT and LPL were "workers." *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 630, 872 P2d 1 (1994).[6] Because the parties **<129 Or App 223/224>** do not dispute the basic facts, the question of worker status is one of law. *Woody v. Waibel*, 276 Or 189, 192, n

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[3] The 1987 version of ORS 656.027 is applicable to this case. That statute has been amended several times and, in particular, subsection (7) was amended by Oregon Laws 1989, chapter 762, section 4.

[4] SAIF conducted the audit for two periods: October 1, 1986, through September 30, 1987, and October 1, 1987, through September 30, 1988.

[5] Wilkes also argues that we lack jurisdiction. SAIF filed a timely petition for review from DIF's properly filed "Revised Order Upon Reconsideration." We have jurisdiction pursuant to ORS 656.704(2) and ORS 183.482(1).

[6] Although *S-W Floor* construed the 1989 version of ORS 656.027, the basic analysis requiring a determination of "worker" status before reaching the issue of "nonsubject worker" status applies to the pre-1989 version of ORS 656.027. *Oregon Country Fair v. Natl. Council on Comp. Ins.*, 129 Or App 73, ___, ___ P2d ___ (1994).

3, 554 P2d 492 (1976); *Cy Investment, Inc. v. Natl. Council on Comp. Ins.*, 128 Or App 579, 583, ___ P2d ___ (1994). *Former* ORS 656.005(27)[7] defined "worker" as

> "any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer."

In analyzing whether NWT and LPL were under the "direction and control" of Wilkes, we apply the "right to control" test. If that test proves to be inconclusive, we apply the "relative nature of the work" test. *Cy Investment, Inc. v. Natl. Council on Comp. Ins., supra; see also Woody v. Waibel, supra.*

The principal factors in the right to control test are:

> "(1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire." *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989).

Under the first factor, the pertinent consideration is Wilkes' control over the method of performance rather than its control over the result to be reached. *Cy Investment, Inc. v. Natl. Council on Comp. Ins., supra.* The direct evidence establishes that Wilkes controlled the result but not the method of performance. Wilkes pointed out the boundaries of the timber to be cut, set a completion date, specified log lengths and required that NWT and LPL perform the job in a "good and workmanlike manner." These specifications deal with the desired result of the contract, not the manner and means of its performance. *Reforestation General v. Natl. Council on Comp. Ins.*, 127 Or App 153, 167-68, 872 P2d 423 (1994).

Other direct evidence establishes that NWT and LPL had the right to control the method of performance. The **<129 Or App 224/225>** parties' contracts specified that NWT and LPL "shall have full control and direction of the work to be performed." NWT and LPL exercised that control: They worked according to their own methods, provided their own equipment and set their own hours. The first factor is indicative of nonworker status.

The second and third factors also support the determination that NWT and LPL were not workers. Wilkes paid NWT and LPL on a different basis than it paid its employees. NWT and LPL were paid by the thousand board feet of logs cut on a single project. Such a payment structure is equivalent to a "fixed sum for a fixed job" and indicative of nonworker status. 1B Larson, *Workmen's Compensation Law* 8-134, 44.33(c) (1993); *see also Reforestation General v. Natl. Council on Comp. Ins., supra,* 127 Or App at 169. The fact that NWT and LPL could obtain draws can be viewed as supporting either worker or nonworker status and does not affect our conclusion. With regard to the third factor, NWT and LPL furnished their own equipment.

Under the final factor, we consider whether Wilkes had the "right to fire" NWT and LPL. There is no direct evidence on the issue, but the contracts indicate that such a right did not exist. The contracts provided that disputes regarding performance be submitted to arbitration and that the nondefaulting party be awarded costs and attorney fees. DIF also found that Wilkes had the right to withhold payment if the job was not properly completed. These terms are indicative of the parties' equal abilities to enforce the contract and are inconsistent with the conclusion that Wilkes had the right to fire NWT and LPL. The fourth factor indicates that NWT and LPL were not workers.

Based on our consideration of the right to control test, we conclude, as a matter of law, that NWT and LPL were not "workers."[8] Because they were not workers, NWT and LPL were not subject to workers' compensation coverage. Although DIF incorrectly determined that NWT and LPL were workers and exempt under ORS 656.027(7), it correctly **<129 Or App 225/226>** disallowed the additional premiums that SAIF charged Wilkes.

Affirmed.

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[7] ORS 656.005(27) has since been renumbered ORS 656.005(28) by Oregon Laws 1990, chapter 2, section 3, and has since been amended by Oregon Laws 1993, chapter 739, section 23.

[8] Because the right to control test is conclusive, we do not apply the nature of the work test. *Reforestation General v. Natl. Council on Comp. Ins., supra,* 127 Or App at 169.

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